European Journal of Palliative Care

THE JOURNAL OF THE EUROPEAN ASSOCIATION FOR PALLIATIVE CARE

Committed to People

11TH CONGRESS OF THE EUROPEAN ASSOCIATION FOR PALLIATIVE CARE

7th – 10th MAY 2009

VIENNA AUSTRIA

Abstracts

EAPC EUROPEAN ASSOCIATION FOR PALLIATIVE CARE

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IM-M017/0054b
Date of preparation: March 2009

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11th Congress of the European Association for Palliative Care (EAPC)
Vienna, Austria, 7–10 May 2009

ABSTRACTS

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Published by **Hayward Medical Communications**,
publishers of the *European Journal of Palliative Care*
a division of Hayward Group Ltd, The Pines, Fordham Road, Newmarket CB8 7LG, UK.

Printed by Latimer Trend, UK

Foreword

Dear Congress participant

Welcome to Vienna 2009!

It is with great pleasure that we present you with this book of abstracts, published by the *European Journal of Palliative Care*. This book offers a complete guide to the scientific programme of the 11th Congress of the European Association for Palliative Care (EAPC). The programme has been put together through the collaborative work of the Scientific Committee and a very active International Multidisciplinary Advisory Board, and represents two years of planning, preparation, review and sometimes difficult decisions. We could not have produced it without the support of Heidi Blumhuber (EAPC) and Sandrina Josephs (INTERPLAN), whom we thank for their support, guidance and patience.

This Congress is entitled 'Committed to People'. As Chairs of the Scientific Committee, our commitment is to offer you a dynamic and innovative scholarly programme that reflects contemporary palliative care. We – a physician and a nurse involved in the delivery of palliative care through clinical practice, research and education – have worked together in partnership to ensure that we would match the ethos that has become the EAPC's – *One Voice, One Vision*. The programme reflects the values and aspirations of all those involved in palliative care. We hope it will give you an opportunity to learn from each other, as we have done ourselves in preparing this Congress.

Our pre-conference workshops and 'Meet the Expert' sessions will provide both the science and art of palliative care, from genetics to music therapy, from understanding palliative care needs to current policy and practice. For the first time in an EAPC congress, the needs of volunteers will also be included. We have brought together an international array of experts, who will share with you their work and their passion for palliative care. You will hear them in our 'Plenary' and 'Invited Speaker' sessions. We are particularly delighted that many editors of key international palliative care journals will be joining us. This Congress will offer didactic lectures, opportunities for discussion, and presentations demonstrating current advances in terms of research, education and policy. Using art and drama, we will try to unfold the rich tapestry that expresses the reality of 21st century end-of-life caring.

Poster presentations are a key part of this Congress. Over two days, about 900 posters will show the wealth of knowledge that now exists in the field of palliative care. As in previous congresses, the best posters will be awarded prizes in recognition of their scientific merit.

We invite you to take part in this interesting programme, and to join in with the many delegates from around the world in celebrating our palliative care heritage, here in this magnificent city of Vienna. Vienna is a wonderful city, full of history and beauty, and we hope you will take the time to visit it.

It is also appropriate that we remember the 'founding fathers' of the EAPC who have left us since the last Congress in Budapest in 2007. Professor Vittorio Ventafridda, Italy, and Professor Charles-Henri Rapin, Switzerland, believed in the benefits that collaboration across the world can bring to the development of palliative care. Here in Vienna, we also particularly remember Sr. Mag. Hildegard Teuschl CS, a pioneer of the Austrian hospice and palliative care movement, who died in February of this year. This Congress is their legacy and we remember them with affection and respect.

We extend our thanks to the members of the local organising committee, who have worked very hard to welcome us here, and to the EAPC Board of Directors and President, Lukas Radbruch, who trusted us to organise the scientific programme.

Most of all, we look forward to meeting you here in this impressive Austria Center Vienna, and hope that you will leave the 11th Congress of the EAPC with your expectations fulfilled, feeling energised for the challenges that lie ahead.

With greetings from the Chairs of the 11th Congress of the EAPC

Friedemann Nauck
Chair, Scientific Committee

Phil Larkin
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Committees

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Plenary sessions

P 2.1

The treatment of cancer pain over the past 30 years: controversies, dogma and evidence

Hanks G
University of Bristol, Department of Palliative Medicine, Bristol, United Kingdom

As in any area of clinical medicine, the management of particular conditions or situations has evolved over a variable time and that process is necessarily characterised from time to time by differences of opinion between experts. Sometimes the contentious points are fiercely debated and this is particularly the case when dealing with difficult issues where the available evidence is equivocal. Usually, there is resolution or compromise, but in some instances differences in opinion and approach remain.

In this presentation, some of the controversies in cancer pain management will be reviewed in the light of current best practice. The lessons to be learned – some old, some new – and the implications for clinical practice will be discussed. Topics will include the oral route for morphine, morphine metabolism, morphine-induced hyperaesthesia and paradoxical pain, opioid rotation, and the effectiveness of pain control in hospital-based palliative care services compared with hospices ■

P 2.2

Challenges and opportunities in large clinical trials of drugs for symptom control

Portenoy R K
Beth Israel Medical Center, Department of Pain Medicine and Palliative Care, New York, USA

Adequately powered randomised controlled clinical trials in a sample that is fully representative of the target population represent the gold standard for clinical evidence of drug efficacy and safety. Many issues must be confronted to bring more of this high-quality evidence to the therapeutics for symptom control used in populations with advanced illness.

The first is to understand the nature of this endeavour, including the positioning of this approach in an evidence hierarchy, the distinction between efficacy and effectiveness, and the differing goals of explanatory and pragmatic trials.

The second is to undertand the methodological challenges, including those that are conceptual and those that are instrumental.

The conceptual challenges include the ethical problem posed by vulnerable populations, the trade-off between finding a signal and losing generalisability in addressing the problem of variation, the management of respondent burden as a barrier to collection of clinically relevant data, the missing data problem during repeated dose trials, the problem of intercurrent disorders and the need for treatment during a study, and the issue of funding sources.

The instrumental challenges include standardisation during multicentre trials, creating methods to safely assess the dose-response, and assessing adverse events in those with serious illness.

There is a still small, but steadily growing, number of randomised controlled trials for symptomatic therapies in advanced illness, which demonstrates the strategies that are now being employed to address these challenges. More work of this type is needed ■

P 3.1

Paediatric respite hospices: are they needed?

Leong D S
The Shooting Star Children's Hospice, London, United Kingdom

The first worldwide children's hospice was opened in the United Kingdom (UK) in 1982. It was the vision of Sister Frances Dominica that grew from her personal experience of supporting Helen (a young girl with a brain tumour) and her family. She recognised that there were many other children and families needing this support and, in response to this need, created Helen House. Since then, a further 40 services across the UK have welcomed children and young people with life-limiting and terminal conditions, together with their families.

There are clear differences between service provision for adults and children with life-limiting and terminal conditions and this plenary session seeks to create a greater understanding of the issues faced by all age groups.

In the UK, hospice care provision for adults is far greater than for children. Most children will live very near an adults' hospice, but may be over an hour away from their nearest children's hospice.

There are potential opportunities of short break provision from both children's and adults' services working together. However, there may be difficulties in planning short breaks for older teenagers/young adults, due to the nature of work undertaken in adults' hospices (largely centred on end-of-life care). Adults' nurses are not always trained in managing the specific health care needs of teenagers/young adults, which would create anxiety for the staff, the young person and their family.

Adults' hospices are now catering more for short break visits, but the demands put upon them for end-of-life care are so much greater and, on the whole, the majority of their patients have oncology diagnoses. In children's hospice services, there are far fewer with such diagnoses (for example, 9% of the open caseload at The Shooting Star Children's Hospice).

One of the differences between adults' and children's hospice care is the involvement of the child's parents and family. Parents are usually the primary carers for their life-limited or terminally-ill child, so it is their voice that the healthcare team listens to when determining care and services for the child or young person.

There is sometimes a question about whether the term 'hospice' is the right term for children's care – and whether that acts as a block to care for some children, as parents have their own interpretation on the word – and about how to promote a public understanding of the concept of hospice care for children.

In the UK, the government has recently issued various reviews centred around eight strategic objectives, including a focus on care being available at a place of the child's choice and increasing emphasis on 24/7 care in the community and the child's own home. This is in line with feedback from families, who in general prefer care and support in their own homes. We can expect this to impact on the future development of new paediatric respite hospices, as the best model of care is explored to benefit the families.

At the end of this session, participants will have:
- Developed an understanding of the concept of children's hospice care
- Considered the differences between hospice care in children's services and hospice care in adults' services
- Developed an understanding of the benefits and drawbacks of children's hospice care
- Considered the issues faced by families without paediatric respite hospices ■

P 3.2

The Budapest Commitments in Vienna I: how it started

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The concept of the 'Budapest Commitments' was launched at the European Association for Palliative Care (EAPC) Congress in Budapest in June 2007, as a collaboration between the EAPC, the International Association for Hospice and Palliative Care (IAHPC) and the World Palliative Care Alliance (WPCA). The aim is to encourage national associations to commit themselves to one or several achievable goals in the development of palliative care. The Commitments – including the goals, the methods to reach the goals and the means of follow-up – are published on the EAPC website.

Commitments from palliative care associations in the following 18 countries are available: Austria, Belgium, Croatia, the Czech Republic, Denmark, Germany, Greece, Hungary, Israel, Italy, Lithuania, the Netherlands, Norway, Romania, Spain, Sweden, Switzerland and the United Kingdom.

The presentation of the Commitments and the follow-up of the results is an excellent opportunity to share experiences, successes and resistances to change in countries with different histories of palliative care, different healthcare organisations and different economical resources ■

P 3.3

Palliative care for older persons – partnership in practice

Husebø B S
University of Bergen, Department of Public Health and Primary Health Care; Red Cross Nursing Home, Bergen, Norway

In the last century, modern medicine made it possible to prevent and treat illness. Nevertheless, since the beginning of human existence, people are born and people die. A hundred years ago, mean European longevity was 49 years and over 50% of the population died before the age of 20.

Today, in the industrialised world, more than half of us will reach at least 80 years of age, while children account for less than 1% of all deaths. Moreover, fewer children are being born and mankind is getting radically older. In all previous epochs, the home was the major arena of birth and death. In the 20th century, in all developed industrial nations, these events underwent a radical transfer to healthcare institutions.

It is estimated that 24 million people worldwide have dementia today. In Europe, the number of people with dementia is approximately 10 million, and is expected to double within the next 30 years. In nursing homes (NHs), 80% of patients have dementia, a progressive irreversible syndrome characterised by widespread impairment of mental function, which includes memory loss, language impairment and behavioural disturbances. Caused by demographics, the mortality rate due to dementia is increasing faster than any other condition, and dementia is the leading cause of death in Western societies.

Specialised palliative care services have proliferated worldwide, initially focusing on cancer care; but they are increasingly expanding to include patients with other terminal diseases, for example dementia. Although guidelines exist, only a small percentage of NH patients receive this competent palliative care at the end of life.

Advancing age is also associated with a high prevalence of pain, estimated to be as much as four times higher than among younger adults. Many elderly, living at home or in NHs, experience both dementia and pain. Unable to communicate, these patients express their pain in ways that are different from those without dementia. Thereby, pain and discomfort may trigger behavioural disturbances, such as aggression and agitation. Instead of pain treatment, approximately 25% of the demented dying patients receive antipsychotic medications and restraints; they die earlier and reduced life expectancy is shown.

For the last twelve years, our team, located in Norway's largest NH, has kept on to the aim of integrating palliative care in dementia care. There are several reasons why we should have expected challenges. NH patients have substantial needs for the multidisciplinary approach of palliative care. In addition, palliative care staff needs support and increased competence regarding dementia care, as in general, so far, they are not prepared to care for patients with dementia-related problems. The lesson learned from palliative care clarifies four main causes of malpractice in end-of-life care for patients with dementia:

- Lack of resources
- Lack of ethical decision-making and communication
- Lack of pain and symptom assessment
- Lack of pain and symptom management.

In this lecture, the main focus will be on the difficulty to assess and treat pain in dementia, the proxy rater function in pain assessment, and challenges regarding the cerebral pain process. The Mobilisation-Observation-Behaviour-Intensity-Dementia (MOBID 2) Pain Scale, a new nurse-administered assessment tool

to register pain originating from the musculoskeletal system and from internal organs, will be presented. Using this instrument, it was demonstrated that patients with dementia have more pain, but have significantly less pain treatment, than those without dementia.

Older, frail persons with multiple illnesses need access to competent palliative care. Their main target is not to die but to live until death becomes their preferred solution. While skills and competence in palliative care are needed, the main challenge is life support, skilled geriatric care and competence in symptom management, as well as communication and ethics ■

P 4.1

Who is a palliative care patient? Defining the palliative care population

Kaasa S[1], Oldervoll L,[1] Hjermstad M J,[2] Løhre E,[3] Knudsen A K,[1] Loge J H,[4] European Palliative Care Research Collaboration

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Evidence-based practice (EBP) is the application of evidence-based medicine (EBM) to daily clinical practice. EBM is offered to the patient to optimise the treament. From a societal perspective, EBM may guide the choice of the most cost-effective treatment to any given group of patients.

Palliative care evidence-based guidelines (EBGs) are developed nationally and internationally, based upon EBM, in order to guide EBP. One critical step in their development is to determine whether the findings from clinical studies can be generalised and applied; consequently, it is fundamental to define the patient population.

To classify palliative care, several core domains have been identified, including 'patient and caregiver', 'professional', 'service', 'health and social policy' and 'research' (Currow *et al*. *J Pain Symp Manage*, 2008).

In order to evaluate key domains for classifying the palliative care patient population from a research and clinical perspective, a systematic review was conducted. This information will be used as a basis for the development of an international dataset on how to classify palliative care patients.

A systematic search in two relevant databases to identify palliative care literature of interest was performed. The search strategy was based on the expressions 'palliative', 'hospice' or 'terminal care' and 'randomised controlled trials', and was limited to English papers on adults with cancer. This obtained 983 hits (MEDLINE 766, Embase 217). All abstracts were read and categorised as relevant or not according to study design, population, type of intervention and endpoint.

Results from this systematic review will be presented, ending up with a first recommendation on domains that are candidates for an international palliative care patient classification system and that may contribute to improve EBGs in palliative care. This set of domains will be further explored through a systematic approach, including expert opinions (Kaasa *et al*. *J Clin Oncol*, 2008) ■

P 4.2

The Budapest Commitments in Vienna II: results so far and the future

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The 'Budapest Commitments' – including the goals, the methods to reach the goals and the means of follow-up – are published on the European Association for Palliative Care (EAPC) website. So far, 22 palliative care associations in 18 countries have contributed. The Commitments include a wide range of topics, from education, research, networking, public awareness, policy and quality to definition of standards and volunteers.

Different organisations have reached different levels of fulfilment of goals and success. The Commitments have been used as an incentive to initiate national advocacy projects. The EAPC will explore possible ways of supporting the member organisations in their work with the Commitments. The experience of the Budapest Commitments can serve as an inspiration for organisations in other European countries and around the world ■

P 4.3

Palliative care for dementia patients and benefits of cross-national longitudinal studies

Van der Steen J T
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Palliative care is as applicable to dementia patients as well as to patients facing other life-threatening diseases. Because of the large and increasing number of people who die with dementia, research specific to end-of-life care in patients with dementia is highly relevant.

The majority of studies performed so far, mostly in the USA, had a qualitative or small-scale retrospective design. Major problems were identified, including overly aggressive curative treatment and undertreatment of symptoms. The evidence base for effectiveness of treatments to provide comfort or increase family satisfaction with care is small.

When trials are inappropriate, innovative alternative designs are needed. Large cross-national longitudinal studies potentially show validity of results in different settings. Previous post hoc combining of US and Dutch studies on pneumonia in dementia patients illustrates benefits of comparing treatments and outcomes and confirmation of validity of findings and instruments. For example, combined analyses addressed effectiveness of oral versus parenteral antibiotics for pneumonia patients. Because post hoc combining of data requires comparability – or more difficult equalising of design and key variables – using similar instruments from the outset is preferable. Ongoing (longitudinal) studies on end of life with dementia share a number of instruments.

A study in the Netherlands assesses recently admitted nursing home residents and associations for early care planning with end-of-life experiences. Preliminary analyses show that addressing palliative care goals shortly after admission is associated with an increase in satisfaction with care towards the end of life. Studies elsewhere may examine similar associations.

In conclusion, international longitudinal studies are preferably designed to complement each other prospectively and are valuable in contributing to the evidence on effectiveness of treatment in end-of-life care in patients with dementia ■

P 5.1

Clinical decision-making around ethics – how well are we prepared?

Simon A
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According to the WHO definition, palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness. The prevention and relief of suffering, the treatment of pain and other problems, physical, psychosocial and spiritual, are aims that determine and motivate the actions of physicians, caregivers and representatives of further professions working in palliative care. They are the core of what could be characterised as the ethos of palliative care.

Such an ethos is an important prerequisite but not a guarantee for good clinical decision-making around ethics. The reason for this is that, in clinical decision-making (for example, when withholding or withdrawing life-sustaining treatment or introducing terminal sedation), there may be differing ideas within the medical team about what constitutes a morally acceptable, necessary or forbidden action in concrete situations, despite general agreement on the basic aims of palliative care. Furthermore, patients and their relatives possess their very own aims and values, which may not be consistent with those of the medical team in attendance. In such cases, it is not sufficient for the various people involved to just recollect their respective ethos. Instead, a shared decision-making process is necessary, in which – by means of talks and exchange of arguments – solutions should be found that all the persons involved, with their respective ethos, are able to accept responsibility for.

Leading such a shared decision-making process requires an ethical competence, which has to be acquired and continually enhanced by training and further education – but also by personal experience and by learning from examples. Some aspects of such an ethical competence are:

- Moral sensitivity
- Sense of responsibility
- Being aware of the people involved in a conflict
- Being aware of one's own values and attitudes
- Being aware of other people's attitudes
- Being able to give reasons for one's own values
- Exchange, comparison and assessment of arguments
- Balancing the arguments, decision-making competence
- Implementation and justification of decisions.

In difficult cases, the process of shared decision-making may be supported by clinical ethics consultation. Relevant structures – for example, clinical ethics committees or clinical ethics consultants – exist in US health facilities nearly all over the country; in Europe, they are also more and more present ■

P 5.2

Reflections on the Budapest Commitments – a project for a quality palliative care in Hungary

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In Hungary, in spite of existing guidelines (2002) and minimum standards (2004), there are still a lot of quality-related problems in the provision of palliative care. One of the major issues is that there is not enough emphasis on the roles and tasks of physicians, as nursing care is dominating. In 2009, the Hungarian National Health Insurance Service is increasing the number of palliative care home services, and this may lead to a further deterioration in the quality of the service. Also, the Hungarian specialists need to examine very urgently the meaning of palliative care.

Within the framework of the 'Budapest Commitments', we have committed ourselves to:

- Develop the quality of palliative care, promote real multidisciplinarity and specify the role of physicians within the palliative care team
- Improve education and training of physicians in the field of palliative care.

To achieve this, we are currently going through the following processes:

- Updating the quality protocols, special criteria and quality control, in collaboration with the Ministry of Health, the National Health Insurance Service, the National Public Health Service and the Medical Officer Service (completion expected in 2009)
- Updating and supervising the realisation of the National Cancer Control Programme (2006) with the help of the National Health Council, with a special emphasis on palliative care development (completion expected in 2009)
- Establishing an inpatient palliative care service in a university hospital (project over the next three years) ■

P 5.3

The impact of palliative nursing, a global perspective

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As palliative care has developed as a specialty of its own, nurses, in many parts of the world, have become more visible in all aspects of palliative care – from establishing services and shaping practice to clinical leadership, sole practitioner roles, management, education, research and policy development. At the same time, in other parts of the world, nursing expertise remains undervalued and underutilised. Despite these disparities, however, the clinical role of palliative care nursing is unarguably central in addressing the core needs of the dying person and their family and carers, particularly in places where healthcare resources are scarce.

Palliative care nurses operate in a variety of clinical settings, where they may work alone or in variously constructed teams. Models of care also vary from specialist consultancy services to primary healthcare providers and acute services.

This session will discuss the impact of the professional role of nurses in palliative care, in particular the opportunities for specialist practice. Nurses play a key role in shaping the future of the discipline, and developing roles for palliative care nursing depends on the foundations that have been laid in our current healthcare systems. So roles such as nurse practitioner and primary health care nurse need to be promoted, with good evidence to back their development.

Increased community awareness of, as well as governments' support for, palliative care will lead to increased demand for service provision. Promoting newer roles for palliative care nursing will involve courageous creativity, particularly in parts of the world where healthcare systems are increasingly struggling to meet needs ■

P 6.1

Narrative and stories in palliative care

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'At the core of the practice of care is storytelling … To attend to a person's stories is to enable his or her self-discovery and that is an act of care.' (Frank, 2009)

To be human is to be in a story. Everyone has a story in their life. Patients' lives are made up of stories. Human beings are storytelling creatures, conditioned by their collective history, not only to report their experiences and emotions in story, but to discover who they are through their stories (Frank, 2009). Through the means of narrative and storytelling, patients recount their pain, suffering and what matters to them and to their families. A story gives us knowledge but it also allows us to acknowledge the person and affirm the experience. Working with illness stories can help maximise and harness the meanings and/or experiences as well as the resources/strengths of patients and families therapeutically. Stories can help patients to find coherence in their lives, to understand the past and to know that, despite all obstacles, there are some choices in how they cope and hope for the future. Stories can be 're-storeyed'.

This presentation will consider the past, present and future of narrative and stories in palliative care. Stories are key to unlocking the holistic model, but there are also dangers and ethical concerns. Dominant institutional and professional narratives can have a negative impact on some individuals and their networks. Examples of the positive power of narratives will be given from narrative medicine, research and education. The presentation will end with a live performance by the BRIT School.

The effect of patient narrative is illustrated through the St Christopher's Schools Project. The partnership between patients and young people, in creating and recreating their stories of life and illness through art, drama and music, aims to introduce hospice to school children in a creative and non-threatening way, to promote healthier attitudes to death and dying in themselves and their teachers, parents and carers. Children and young people are linked up with patients reaching the end of their lives. The children and young people listen to the patients' stories and ask questions. The four-session project involves the wider school community and is proving a major tool in St Christopher's health promotion and public education strategy. It is featured as an example of innovative practice in the UK's first End of Life Care Strategy published in 2008.[1]

The experience not only allows young people to explore and create healthier attitudes towards illness, loss, death and bereavement in relationship with a real patient, but also offers an opportunity for that patient–pupil narrative to speak to the wider world ■

Patient's comment
'I came alive when the teenagers were here … they've got all their life ahead of them.'

Young person's comment
'I felt happy doing the art work … it took my mind off death and put my mind on understanding that we all have to die some day.'

Patient's comment
'I'm glad you take this seriously. I feel I've got something that the children can learn from.'

Young person's comment
'At the start I felt a bit shakey 'cos I thought it would smell and be full of sick people, but they were just normal.'

Reference
1. Department of Health. *End of Life Care Strategy. Promoting high quality care for all adults at the end of life*. London: DH, 2008.

Parallel sessions

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PS 01 Is research collaboration all talk and no trousers? Lessons from the UK "cancer experiences" (CECO)

PS 01.2

Sharing experiences on working collaboratively and setting up a successful collaborative

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Background: The Cancer Experiences Collaborative (CECo) is an initiative to improve the quality and quantity of supportive and palliative care research in the United Kingdom that was funded for 5 years by a national consortium after a competitive tendering process in 2006. CECo brings together leading research centres based in five universities, together with cancer patients and family carers (called research partners), four large hospices and many key stakeholders such as Help the Hospices. CECo aimed to deliver: increased research grant capture, high quantity and quality outputs, capacity building at all levels of research, greater engagement with research partners.
Aims: This paper outlines the processes adopted to develop and sustain joint working practices, establish good governance and to achieve sustainable work streams within CECo, from its inception, and over the following three years.
Methods: The organisational structures and governance and monitoring systems required in this type of initiative will be presented, including reflection upon the transitions in working and leadership styles required during the development of the collaborative.
Results: Evidence of the challenges and strategies used in the organisation and leadership of a collaborative will be demonstrated, in addition to reflections on processes that required adaptation.
Conclusions: There are important transferrable lessons to be learnt from the CECo collaborative which are potentially applicable to other countries and organisations seeking to establish similar initiatives.

PS 01.3

Collaborating with research partners: involving people affected by life-limiting illness

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Background: Collaboration with people affected by life-limiting illnesses in health research is widely promoted within the UK. User involvement aims to help ensure that research is undertaken that reflects user priorities and perspectives. The Cancer Experiences Collaborative (CECo), is developing user involvement through engagement with research partners (members of the public and service users).
Aims: This paper outlines the processes adopted to develop and sustain research partner work within CECo, from its inception, and over the following three years.
Methods: Different processes and activities have been adopted within CECo's user involvement work that reflect a range of different consenting, consulting, cooperative and collaborative relationships (Tripp 1998). Involvement has occurred in the design and management of specific studies, and also entails oversight roles within the Collaborative's management structure. A new initiative in the form of a Research Partner Forum has been established to provide regular contact between the research partners and CECo researchers.
Results: A core group of research partners has been established within one CECo partner university and provides input into the design of studies across the research collaborative. This forum is also developing its own research programme. Other individuals have become involved with the other partner universities in a range of roles. The work is not without its challenges in terms of ensuring appropriate training and support and the management of expectations from all parties.
Conclusions: There are important benefits to CECo and to research partners of developing sustainable user involvement across all its activities. Appropriate attention also needs to be paid to the demands that arise when seeking to integrate user involvement into research activity.
Funding Source: NCRI

PS 02 EPCRC – Improving assessment and classification of cancer pain – the Why, the How and the Progress?

PS 02.1

Assessment and classification of cancer pain: why do we need to improve?

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Failure to formally assess pain is a barrier to optimum cancer pain (CP) management. The formal use of CP assessment and classification tools has been inconsistent in clinical practice. This may be due to a mix of instrument and clinical environment related factors: choosing from a confusing multiplicity of tools; lengthy and burdensome tools in the frail advanced cancer population; failure of scores to intuitively communicate clinical information or be available at the site or time of clinical decision making, and the consequent difficulty of integrating the assessment instrument into clinical practice, and not least the cumbersome completion of scores on pen and paper. Expert consensus has identified 10 pain dimensions, ranked according to importance for pain assessment in palliative care: intensity, temporal pattern, treatment and exacerbating or relieving factors, location, interference, quality, affect, duration, beliefs and history. The choice of instrument will depend on the location of care, adaptability to follow-up reference interval, burden and the option of proxy ratings. A selection of validated instruments will be discussed with emphasis on their limitations. A CP intensity score captures not just pure nociception but the patient´s expression of pain. Non recognition of other non-nociceptive and therefore non-opioid sensitive components of CP expression may occur in unidimensional assessment. The original Edmonton Staging System for cancer pain assessed many other domains relating to the CP presentation, including CP mechanism, CP characteristics, cognitive function, opioid dose, psychological distress, opioid tolerance and addictive behavior. The limitations of this tool and its more recent versions, including the Edmonton Classification System for CP (ECS-CP) will be discussed. Further research necessitates international collaboration to establish uniformity and avoid confusing disparities in the approach to cancer pain assessment and classification.

PS 02.2

Improving assessment and classification of cancer pain - how can we improve?

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One of the aims of the European Palliative Care Research Collaborative (EPCRC) is to achieve consensus on a classification system for cancer pain. As a first step, a systematic literature review was performed in order to identify existing classification systems and domains / items used to classify cancer patients with pain.
In a systematic search in the Medline and Embase databases, covering 1986-2006, the search strategy was based on the terms "classification" or "categorisation" or "staging" or "grading", and "neoplasm" or "cancer", and "pain". Only papers in English assessing adult patients were included. All reports were systematically evaluated by two independent readers.
692 hits were obtained of which 92 papers were evaluated to address pain classification.
Six standardised classification systems were identified. Three of them were systematically developed and partially validated; the Classification of Chronic Pain of the International Association for the Study of Pain (IASP), the Edmonton Classification System for Cancer Pain (ECS-CP) and the Cancer Pain Prognostic Scale (CPPS). Both pain characteristics and patient characteristics relevant for cancer pain classification were included in the classification systems. All but one of the standardised systems aim at predicting treatment response or adequacy of treatment. Several domains and items used to categorise cancer pain but not formally described as part of a classification system, were also identified and systematised.
The existing approaches to pain classification in cancer patients are different, mostly not thoroughly validated, and none are widely applied. An internationally accepted classification system for cancer pain could improve research and cancer pain management. To achieve this, further research will include patients' and experts' opinions, analyses of existing data sets on cancer patients having pain, and empirical data collections.

PS 02.3

What progress have we made?

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Background: Literature reviews from the EPCRC (European Palliative Care Research Collaborative) shows that a plethora of pain assessment tools are in use and that tool development is a continuous process, often not adhering to accepted guidelines. The systematic work of the EPCRC is based on international, step-wise, iterative processes by clinicians, basic scientists and researchers with literature reviews, expert/patient interviews and data collections.
Aims: A major EPCRC objective is to improve pain assessment through international consensus on content, methods and interpretation. An ongoing international data collection in palliative care (PC) cancer patients, EPCRC-CSA, aims to test the second version of a computerised assessment tool, based on data from a prior national study (PAT-C).
Methods: PAT-C was fully computerised, primarily assessed pain and covered the dimensions: intensity, interference, location, temporal pattern, exacerbation/relief. 395 PC (M: 53%, age 63) and 168 chronic pain (CP) patients (M: 32%, age 46) were recruited. The EPCRC-CSA started in Norway in Oct 2008, has included 150 PC patients and aims to recruit 1400 from 19 centres world-wide.
Results: PAT-C results showed that pain intensity and interference were highly correlated (r=0.81), but their relationship differed in PC patients vs. CP patients, indicating that one or both are reported differently by the two groups. PC patients may find it difficult to know whether functional limitations are due to pain, indicating that pain interference may be less reliable in this group. Psychometric analyses supported keeping the dimensions conceptually distinct, although it may be possible to form a summary score. Assessment by computers was well accepted.
Conclusion: The PAT-C analyses supported the a priori opinions of the experts, that intensity and interference should be assessed as two dimensions. The international collaboration in PC represents notable progress for consensus-based research

PS 03 OPCARE – addressing End of Life Issues

PS 03.1

Signs and symptoms of approaching death

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OPCARE9 is not a research project but a collaboration for defining further fields of research. The dying phase especially in hospital settings has often been claimed to be "underdiagnosed". In consequence, team conflicts,

"futile treatment" and insufficient symptom control are reported frequently. There is a need for diagnosing dying more accurate.
Methods: 3 different methods have been used to analyse phenomena for the dying phase: a systematic literature review, an internet- based search for phenomena reported in fiction literature and in internet fora, and a Delphi process among different target groups in different countries and among professionals and non- professionals.
Results: 1) a list of 32 different phenomena of approaching death could be extracted from the Delphi process. There is a clear difference in the rating as being an important phenomena between professionals and non- professionals.
2) "Dying" is not a Medical SubHeading (MeSH- Term), a fact that not only reflects the lack of clear definitions for this phase of life, but also the lack of research in this field in the medical world. Any literature search for this kind of phenomena needs to include non- medical literature and even fiction.
3) There is no evidence until now for having a set of signs and symptoms (i.e. diagnostic test) with a reasonable accuracy for predicting the dying phase.

PS 03.2

OPCARE9: End of life decisions

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The OPCARE9 project aims to identify important lacks in knowledge in order to improve end-of-life care for cancer patients. One of the issues concerns end-of-life decision making. To determine the international scope of end-of-life decisions first of all an informal inquiry was performed.
An end-of-life decision was defined as 'a decision involving a person who is in the last days of life that has (may have) a significant impact on the quality, place and/or time of dying'. In 9 countries relevant stakeholders (e.g. physicians, nurses, and psychologists) were asked which end-of-life decisions they consider to be important.
We received responses from 91 stakeholders from 7 countries (Argentina, United Kingdom, Germany, Sweden, Switzerland, Slovenia, and the Netherlands), who reported in total 696 end-of-life decisions. These decisions could be ordered into 12 categories. The categories 'life-prolonging medical treatment', 'place of dying', 'symptom management' and 'information and communication' contain 62% of all decisions.
Important life-prolonging treatment decisions in the last days of life concerned withholding/withdrawing cancer-directed therapy, and artificial hydration and/or nutrition. The place of dying (at home or in an institution) and how to control symptoms (palliative sedation, appropriate drugs) also involve important decisions. Finally, deciding about the content, timing and style of communication with the patient and relatives in the last days of life was frequently mentioned as an important topic.
So, within the international community there seems to be agreement about the importance and relevance of certain end-of-life decisions. Our findings give an excellent starting point for the follow up of the project, where gaps in knowledge concerning important end-of-life decisions will be explored in a systematic literature review and a Delphi process, in order to identify shared (and diverging) opinions about future research challenges.

PS 03.4

Psychological and psychosocial support for cancer patients in their last days of life

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Psychological and psychosocial support (PPS) for cancer patients is consistently reported in literature as an essential part of palliative care, able to ameliorate substantially their quality of life. However, little is known about the scope and utility of PPS for cancer patients in their last days of life.
Therefore the main objective of this project is to
(1) define the scope and contents of PPS by expert view and
(2) evaluate the number and content of articles published on PPS
Research questions include: What do we know about the natures of psychological and psychosocial suffering and support addressing this in the last days of life?
What influences the extent and quality of psychological suffering in the last days? Is this different from psychological and psychosocial suffering before the onset of the last days of life?
Needs Assessment
What do we know about the epidemiology of psychological and social suffering?
How do the needs (macro or micro) differ between the different stakeholders?
How do the needs differ between contexts?
How the needs of the different stakeholders are interconnected?
How needs can be assessed - by whom, by what instruments/ procedures, who should be addressed for it (patients, family members, staff)?
Technology: What interventions are available to address these kinds of suffering and what can be achieved by them?
How well meet the interventions the need for psychosocial and psychological support?
How interventions manage to address conflicting needs?
What preconditions exist for working interventions?
Quality indicators: What quality indicators can be found?
Methods used are:
(1) Delphi methodology among experts in the field of palliative care from all 9 OPCARE9 countries (and additionally Romania)
(2) Systematic literature review in 5 databases (MedLine, PsychInfo, PsychLit, CINAHL, CancerLit)
Current results are going to be presented.

PS 04 PRISMA session: Culture in end of life research

PS 04.1

What is culture and why is it important for understanding priorities at the end of life

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In discussions about the provision of adequate health care the term "culture" is used widely, though it is defined loosely, if at all, and there is little critical reflection on either the diverse meanings of the term or the assumptions that underlie its use. Culture tends to be equated with ethnicity and seen as both the main causal factor behind the health behaviour of minority groups as well as the key to the appropriate delivery of care to these groups. It is argued that end of life care should be culturally sensitive, taking cultural diversity or the cultural backgrounds of patients and their families into account, and care providers are assumed to require training in cultural competence to deal with patients from diverse backgrounds.
Sensitivity to cultural difference is an essential aspect of a holistic palliative care, particularly in the multi-ethnic context of many European societies, but a more precise and more critical approach to culture is required if this is to be fully realised. This needs involve going back to the anthropological concept of culture as largely unconscious conceptual models that underlie, influence and structure the ways in which people think and act in practical situations. This definition includes not only the norms and assumptions underlying the needs and the behaviour of "ethnic minority groups", but also those of palliative care and its providers themselves. This enables the recognition of diversity in the ostensibly uniform model of biomedical care (for example in the ways in which "end of life" are defined in different settings) thus facilitating a better fit between provider and patient models.

PS 04.2

A call for expertise for the development of a European network of experts on culture and end of life care

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Background: PRISMA is a EU programme aiming to inform best practice and research in end of life care for cancer patients across Europe through comparison and exchange of approaches and experiences in measurement and research priorities. One of its foci is to develop collaboration on culture and end of life care.
Aim: To present a preliminary comparative analysis of the 'call for expertise', which is still ongoing, and consider its use and usefulness.
Methods: A document consisting of: a call for expertise and a brief questionnaire, to identify the most knowledgeable experts on cultural issues in end of life care, using a snowball sampling approach. It was sent by e-mail to people the research team knew, to those identified through the literature, to a list of European palliative care associations and to conferences targeted at palliative care professionals covering issues on culture.
Results: We identified 41 'experts'. The questionnaire has a response rate of 30%. The majority of responses came from the UK. There were fewer responses from the rest of Europe. We received feedback to the questions as being too broad for an accurate reply. Through an inclusive approach an understanding is obtained of the 'expertise' that exists in this area, in which disciplines it is to be found and who expresses interest in this topic. The answers to the five open questions show distinct issues by country. They give different interpretations of the concept 'culture'.
Conclusion: The call for expertise is a flexible instrument for the development of an unexplored area of research. Its inclusive approach allows to explore the variation in interpretations of culture and identify where the expertise can be found and what it entails, as it is moulded by the respondents. It is a time-consuming tool for both sides but the information it generates makes it worth the effort.

PS 04.3

Making culture relevant to End of Life practice: An overview of approaches to cultural competency

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Background: Attempts to provide equitable care in palliative care settings for minority ethnic groups have been heavily influenced by 'cultural competency models'. The impetus for development of these models came from increasing evidence that minority ethnic groups experience unequal access to palliative care and hold distinct end of life preferences.
Aims: Discuss definitions of 'cultural competency'; give an overview of models used; evaluate the appropriateness of models for palliative care settings; and consider the impacts of cultural competency training on healthcare professionals' practice.
Methods: A systematic review of cultural issues in end of life care in the UK was performed using the databases: WoK; Cochrane Library; OVID; Cancerlit; ASSIA; and CINAHL. 129 documents met inclusion criteria; 98 were available for full assessment.
Results: The results from the review of cultural competency are presented. Definitions of cultural competency ranged from narrow interpretations meaning increased specific cultural knowledge to broader interpretations including cultural awareness, sensitivities and skills. Cultural competency was seen as a process and models were intended to be applicable in practice. The need for training of healthcare professionals in cultural competency was a recurrent theme. The literature, however, revealed ambiguity concerning the appropriateness of cultural competency models for use in palliative care settings, concern that a focus on cultural knowledge could lead to stereotyping, and a paucity of literature on the impacts of interventions.
Conclusions: The literature demonstrates various understandings of 'cultural competency', and ambiguity concerning its appropriateness and effectiveness in practice. Research is needed to clarify cultural competency and its application in palliative care settings. In addition, research is needed to investigate healthcare professionals' agency in applying 'cultural competency' policy.

PS 04.4

The experience and expression of pain: the influence of culture and ethnicity and implications for palliative care

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Theories of pain have traditionally been dominated by biomedicine concentrating upon its neurophysiological

aspects, both in diagnosis and treatment. In this presentation I argue that a major obstacle to a more adequate conceptualisation of pain is the manner in which it has been ´medicalised´, resulting in the inevitable Cartesian split between body and mind. Scientific medicine has reduced the experience of pain to an elaborate broadcasting system of signals rather than seeing it as moulded both by the individual and their socio-cultural context.
Although pain lies at the intersection between biology and culture, until recently relatively little attention has been paid to understanding this relationship and how it potentially influences care and treatment. Other equally important issues governed by culture about the meanings and expression of pain are now being discussed. I will present evidence, quantitative and qualitative, to show that (i) not all social/cultural groups respond to pain in the same way; (ii) the perception and response to pain can be largely influenced by our cultural background; (iii) how, and whether, people communicate their pain to health professionals and to others, is also influenced by cultural factors.
Cicely Saunders proposed the concept of 'total pain' which includes important patient-centred concerns involving psychological, social, emotional, and spiritual dimensions, all of which are culturally patterned. 'Total pain' is inextricably tied to a sense of narrative and biography and emphasizes the importance of listening to a patient's story in order to understand their experience of their distress and how they want it to be managed. A greater appreciation of how culture influences pain, and the skills required to engage in conversation among diverse populations to elicit their beliefs and concerns will be discussed.

PS 05 Neurology and non-cancer in palliative care

PS 05.1

The wish for hastened death in neurological palliative care. How do we approach the issues?

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Patients in palliative care who "want to die" represent a clinical and ethical challenge. In tumour patients, about half have this wish for hastened death (WhD) at least intermittently, about 10% strongly and persistently. Clinical experience suggests that this wish may be even more pressing in patients with more chronic and physically debilitating situations such as in many neurological conditions.
For teams palliative care teams, these patients initiate quite a few uneasy questions, e.g. How do we react? Could we understand a patient´s wish in specific circumstances? How does this relate to our palliative care philosophy, and what effect does this discussion have on the team? Should we wait until patients bring this topic up, or would it be safe to start that discussion upfront? What do patients really mean when they mention this to us? How much is this wish changeable, and how hard should we try?
Current research has shown that a WhD has to be seen by the team as a quite differentiated phenomenon. First, the WhD may show itself in various intensities. Only few patients explicitly ask for death on request or assistance in dying, some patients, however, would feel a strong WhD, but not dare to mention it, especially in a palliative care situation. Are we prepared to identify those patients? Furthermore, quite a few patients see a WhD as a hypothetical option should the future get worse.
Second, a WhD may change over time spontaneously, and may therefore also be a target for our therapeutic interventions. But do those address all relevant reasons? Symptom control is obviously important, but what about fear, hopelessness, feeling of burden to family? What would be necessary improvements in our palliative care inventions?
Thirdly, the wish to die and the wish to live are intertwined phenomena, and do not at all exclude each other. Even a patient with the most pressing WhD may have a strong will to live, and it is our task to identify this.

PS 05.2

Challenges in the palliative care of ALS/MND

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The management of people with Amyotrophic Lateral Sclerosis (ALS) / motor neurone disease (MND) is changing with the increased use of ventilator support and gastrostomy feeding. There is increasing evidence that these interventions improve quality of life and, in the case of ventilatory support, increase prognosis. Although these interventions may be helpful there are increasing challenges in the discussion with patients and families about their use. The discussion may need to occur earlier in the disease progression, as there is evidence of frontal lobe dysfunction in an appreciable number of people with ALS/MND as the disease progresses. Thus discussion about future care may need to be started before the patient develops severe swallowing or breathing problems, but while they are able to be fully involved in the discussion. This can be a challenge to patients, families and professionals.
The interventions may be helpful initially but as the disease progression continues and the person may become more disabled - both physically and, in some cases, mentally. Discussions about these issues should ideally occur when the intervention is commenced so that with advance care planning all involved, patient, family and professionals, are aware of the wishes of the patient. As the disease progresses there may be the need for discussion about the withdrawal of the intervention, with all the ethical and practical issues this involves.
There is the need for specialist palliative care services, which may be able to help in these difficult discussions, to work in a collaborative way with neurology and rehabilitation services so that interventions can be successfully commenced, with full discussion of their implications and with clear and agreed advanced care plans.

PS 05.3

Psychosocial interventions in neurological palliative care patients and their families

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Palliative care professionals often report significantly lower satisfaction when caring for neurological vs. cancer patients, mainly due to higher workload, communication barriers and "difficult relatives". A possible explanation for this observation may be that the palliative care concept of oncological patients cannot be applied unaltered to neurological patients. Overall, there are many identical stressors and needs; however, neurological palliative patients also have specific characteristics that pose particular challenges: First, it is clear from the very beginning that there is no cure - this is the case with neurodegenerative diseases, with MS and with malignant brain tumours. How does this influence the concept of hope?
Secondly, due to new therapy approaches, the course of the illness is often considerably prolonged, and resembles chronic illnesses. Additionally, the speech of many patients with ALS is affected due to the disease, and patients with malignant brain tumours are often cognitively impaired and suffer personality changes. What kind of psychosocial intervention is needed in this clientele?
Open communication between patient, family, health care professionals enables individuals to discuss concerns freely. Providing significant information like prognosis, possible side effects of the disease and also information on available support is essential. Medico-legal issues arise in illnesses that cause cognitive impairment. The advice of a social worker is then needed to arrange an appropriate power of attorney or advance directives. Carers face conflicting demands, for example juggling employment with the demands of caregiving. Therefore, practical help is a priority. Often strong emotional responses occur, e.g. anxiety, anger, depression, and denial - both in patients and in their relatives. Therefore, a psychologically informed approach to family care with specialist interventions, where needed, can help throughout the disease journey.

PS 06 Palliative care in the community: coming of age

PS 06.1

Palliative care in the community: coming of age

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Palliative care in the community has significantly advanced in many countries throughout the world. This symposium will highlight exciting clinical, conceptual and research developments in different countries in the last few years. After this introduction, we will learn of the most significant development in England to make palliative care accessible to all. Then from Australia we will learn of clinical and research innovations in the community. The last presentation will illustrate from Scotland the potential of longitudinal qualitative research in the community.
Palliative medicine has achieved huge strides in the last 40 years. Hospices now deliver excellent specialist palliative care, but do not reach most dying patients. Developing palliative care services in the community (now called Primary Palliative Care) is important to reach and serve the whole population, and to provide care where many people wish. Such services can moreover provide care from diagnosis of a life-threatening illness, and to people with non-malignant conditions and older persons who have comparable concerns to and in some cases even greater and more prolonged unmet needs than people with cancer.
Primary care professionals share common values with palliative care specialists - holistic, patient centered care, delivered in the context of families and friends, and are well placed, if trained and supported, to provide care to all.
Given the increasing public expectation around palliative care for all in need, it is important and timely to prioritise and take forward research in this setting. This research should address all issues of adjusting to life after diagnosis, including symptom control, psychological wellbeing, social aspects, and existential concerns. This is a challenging arena, but rapid progress has been made in recent years in developing conceptual models and research architectures for progressing descriptive and intervention studies.

PS 06.2

GSF - internationally relevant to facilitate quality care in the community

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"We can't get it right until primary care does it right"
"GSF is the bedrock of generalist palliative care"
Most care for patients towards the end of life is delivered by the usual healthcare provider- often the GP and community nursing team. Enabling primary care to provide high quality end of life care is vital, and no national strategy will work unless this important area is addressed.
The Gold Standards Framework (GSF) in Primary Care is a framework to deliver a 'gold standard' of care for all patients nearing the end of their lives. It includes tools and resources for generalists to optimise the care for all patients with life-limiting conditions, in roughly the final year of life. GSF focuses on enabling and releasing the abilities of generalists, to better dovetail working with specialists.
Over the past 8 years GSF has successfully changed the face of community palliative care provision in the UK. It is now mainstreamed in policy as part of the NHS End of Life Care Strategy, endorsed by the Royal College of General Practitioners, NICE and others. Over 90% GPs hold palliative care registers and planning meetings, and over 60% using GSF more fully. Based on best available evidence, evaluation is integral to the work, demonstrating improved quality of care, reduced hospital admissions and deaths, more dying where they choose, better team-working and greater staff and carer satisfaction.
GSF is extended to other settings- the specific GSF Care Homes Training Programme used by almost 1000 nursing homes, GSF Acute Hospitals pilots, GSF in prisons, GSF for children etc. Several countries are adapting GSF for their own system with similar early success. We believe it is internationally relevant as part of the answer to facilitate quality care in the community and welcome the opportunity to support others wishing to achieve this important goal of best

care for all dying people- a gold standard of care for all.
www.goldstandardsframework.nhs.uk
www.omega.co.uk

PS 06.3

Palliative care in the community in Australia

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Community based palliative care in Australia is shaped by its geography and the nature of its health system. Australia is both highly urbanised, yet at the same time has extensive areas with sparse population and scarce health resources. Access to the health system is through the patient´s general practitioner (GPs), who refers the patient to relevant health professionals and services. Palliative care services vary from tertiary level specialist services to single non-professional health professionals with a special interest in palliative care. Aged care is conducted in government supported care homes with different levels of intensity of care.
Palliative care has been supported through a comprehensive national program to improve quality, accessibility and coordination. Initiatives include development of a uniform national undergraduate palliative care curriculum, improved access to palliative care medicines, demonstration grants to improve coordination between palliative care services and community services; enhancement of rural palliative care, the development and implementation of guidelines for care in aged care facilities; and work on indigenous palliative care.
Have these programs improved outcomes for community palliative care? The effectiveness of palliative care in the community is contingent on the support of Australia's GPs, approximately 75% of whom conduct palliative care. Major challenges are: 1. To identify the characteristics of those who are not participating in palliative care so as to improve participation rates; 2.maximise effectiveness of the system by improving integration between specialist teams and GPs; 3. providing on-time education to ensure quality; and 4. improving GP skills and techniques through testing innovative interventions.
This presentation will offer examples of this work: there are major challenges but exciting opportunities available.

PS 06.4

Do family caregivers have typical trajectories of psychological, social and spiritual needs in supporting someone dying of cancer?: serial qualitative interviews with patients with lung cancer and their family carers

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Background: Typical trajectories of physical decline have been described in people with cancer, organ failure and the frail elderly. We have previously described and mapped out characteristic patterns of social, psychological and spiritual distress for people with cancer from diagnosis to death.
Method: We undertook a secondary analysis of serial qualitative interviews with lung cancer patients and their carers from diagnosis to death, in which we asked carers not only about their impressions of the needs of the patient, but also about their own needs
Results: Family carers witness and may share the illness experience of the person who is dying. Although they may not suffer from the patient's physical disease, their social lives may be disrupted, they may suffer psychological distress (such as anxiety and depression as they see their family member suffer), and the suffering witnessed may cause them to think about the meaning of and purpose of life themselves. Family carers had their own physical needs which were different from the patients´, but where this impacted on their ability to care had added significance.
The specific social issues were frequently different as were the specific psychological problems but at different points of the illness trajectory particularly at diagnosis, deciding about treatment, getting home, disease progression and death each were stressed in the same three dimensions at similar points in the illness trajectory.
Conclusion: The multi-dimensional experience of distress suffered by patients was typically reflected in the suffering of their carers in the social, psychological and existential domains, and we have mapped this out visually.
We consider that family caregivers may have typical trajectories of psychological, social and spiritual needs in supporting someone dying of cancer in parallel with the patient. This has implications for carer support from diagnosis to death and bereavement.

PS 08 Palliative care in older people - End of life care in long-term care facilities

PS 08.1

Long term care facilities as discursive environments: implications for end of life care

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This presentation provides an overview of an ethnographic study informed by the symbolic interactionism perspective (Parker, 2008) to explore the social experience of death and dying in Australian residential aged care facilities. Drawing on the work of Gubrium & Holstein (2000,2001) the concepts of discursive environments and institutional identities are used to illuminate the mediating role of institutions, such as residential aged care facilities, in the construction of the self in society. With respect to dying and death in these settings the study provides evidence of how Australian residential aged care facilities as discursive environments provide institutional templates for the construction of self identity for dying residents. The discursive environments of the two residential aged care facilities embraced the revivalist discourse of a palliative approach for dying residents. This revivalist discourse was evidenced by discursive practices within the environments that acknowledged death and dying and embraced self identity, values, biography and relationships between dying residents, their family and staff. However, this revivalist discourse was overshadowed by the biomedical and economic discourses which were dominant in these settings and which dictated the possible institutional templates that were available for dying residents to construct their identity. Four possible templates for self construction for dying residents were proposed. These were the economic self reflecting the presence of an economic discourse, the embodied and dying selves which were created to serve the economical and biomedical discourses and the other constructed self for those whose resources of identity construction are limited.

PS 08.2

End of life care for older people in long term care: a system and life world perspective

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This paper reports on an action research study (Hockley 2006) that was undertaken to develop staff knowledge of high quality end-of-life care for older people resident in nursing care homes [NCHs]. Working with two independent NCHs, exploratory work confirmed specific contextual and clinical issues related to end-of-life care and highlighted that dying was peripheral to the care culture where the emphasis was on functional rehabilitation. In each NCH, an initiative, inductively derived from discussion with staff and based on the exploratory phase, was devised and implemented. In the first NCH, the initiative entailed development of 'collaborative learning groups' (CLGs) which took place following the death of a resident. In the second NCH, a group of NCH staff, managers and local GPs adapted the Liverpool Care Pathway for the last days of life; this was then introduced through an intense education programme and used prior to the death of a resident. The documentation provided a system around which high quality end-of-life care could be promoted. Both actions were evaluated. These initiatives enabled a greater openness towards death and dying in both NCHs.
The session presents a conceptual model for developing practice that acknowledges the importance of both the lifeworld of staff in their care of dying residents and their families alongside the nursing care home system. This model, and the process of undertaking the action research, is discussed in relation to Habermas's Theory of Communicative Action - a substantive theory of 'system' and 'lifeworld'.
This presentation provides the prelude to third and fourth papers where a new theory and it's application is presented which also incorporates the theoretical concepts explored in paper 2.

PS 08.3

A contested state in a contested space: theoretical understandings of living and dying for older people in care homes

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In many Western resource-rich countries, older people live and die in long-term institutional care settings. The provision of high quality end of life care for older people residing in such setting is receiving increased attention. However, knowledge about living and dying in these settings remains largely under theorised, which limits our understanding of how to influence the development of quality end of life care in the setting. This paper argues that theory can elucidate the experience of living and dying in care homes. We extend Stafford's model of the nursing home as a cultural space through the use of Habermas's theory of communicative action and Gubrium's discursive practices to understand better the dynamics that shape living and dying for individuals and the wider organisation. We propose a new conceptual model that shows how older adults dying in care homes occupy a contested state with respect to their positioning on the living-dying continuum. How individuals themselves attribute their status as living and/or dying can be contested. Care homes are also contested places, located in wider systems, which are influenced by a range of economic, quality and regulatory drivers. A number of living-dying discourses (consumer, professional and societal) mediate the life world and wider system in a communicative space. These discourses act as drivers and shape older adults' experiences of living and dying in the care home. The proposed model has transformative potential to illuminate current and future practice in end of life developments in long-term care settings.

PS 08.4

Translating theory into practice: Strategies for transforming long term care facilities

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This paper is the final in this symposium "End of Life Care in long term care facilities: Theoretical and Practice Perspectives". This presentation will illustrate how the model presented in this symposium has transformative potential to illuminate current and future practice in end of life developments in long-term care settings.
The conceptual model presented here offers diagnostic and remedial direction to improve the experience of dying for older people living in care homes. This model can be used diagnostically to help identify the different discourses present in care homes. By identifying which discourses are dominant, initiatives can be tailored to them in order to achieve support for their implementation. This conceptual model attempts to identify discourses that shape individual's experiences of living and dying in long-term care facilities. Attention to these discourses may facilitate more effective ways to deliver end of life care in these settings.
At a remedial level, we would argue that both the lifeworld (micro) and system (macro) need to be considered and addressed within initiatives that seek to improve the experience of living and dying in care homes. For example, in England the national End of Life Care programme advocates the use of various tools that have been developed to ensure individual's needs are identified and met. However, on their own these tools are not sufficient. Using this model it is not enough to put 'tools' in place to help people manage dying. The lifeworld is of equal importance, which requires human experiences to be addressed, encouraging 'right action' or greater compassionate care by carers or enabling residents to voice their fears

about death. The recognition of communicative (discursive) space and the possibility that this can be created provides another.

PS 09 Europal: Best Practice in Palliative Care

PS 09.2

Organisation of Palliative Care in seven countries

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Aim: The 3-year EU-funded project EuroPal: Best Practice in Palliative Care aims at identifying quality indicators for the provision of palliative care. One step of the research programme included the compilation of national inventories of palliative care (PC) of the participating seven countries (Belgium, France, Germany, The Netherlands, Poland, Spain, and United Kingdom).
Method: Development of a questionnaire (focus group) for collection of data on the state of art of the organisation of PC using publications, grey literature (acknowledged sources), and interviews with national experts and policy makers.
Results: The topics covered in the inventory were:
1. Health systems with regard to provision and funding of PC,
2. Systems to measure PC needs of the population,
3. Laws on PC,
4. National and/or regional policies on PC,
5. Health plans regarding palliative care and their implementation,
6. National/regional PC associations,
7. Barriers or incentives to provide or receive PC,
8. Role of volunteers in PC, organisations and training of volunteers,
9. Place of death,
10. Numbers and description of PC resources,
11. Research (national/regional research plans, funding),
12. Education and specialisation in PC.
Parts of the results of the inventories were used to develop a questionnaire on organisation, process and outcome of models of PC in the seven countries that are recommended as excellent services by experts from the respective countries. Important results of data collection are presented.
Conclusion: A careful process of agreement on definitions and terms, including the preparation of a concise glossary, is needed to facilitate even descriptive compilation of information from different countries. Interviews with national experts and access to grey literature are key instruments for the coverage of most recent information.

PS 10 Bereavement and Loss

PS 10.1

Lost: Dementia and (dis)enfranchised grief

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Disorientation in time and place is currently a popular TV adventure fiction ('Lost'). In media reality exploration of these topics serve as popular entertainment. In the 'real world', however, friends and families affected by dementia are usually hidden from view. Grief is the constant yet hidden companion of Alzheimer's disease and other related dementias. Grief can arise when an individual in the early stages of the disease encounters the symptoms fearfully and anticipates the loses that the disease entails. Grief will certainly be experienced by family members as they view the slow deterioration in the memory and even the being of the person they love. Grief will increase as family members see that a stranger emerges from that decline - a stranger who needs unceasing care.
We have to consider and appreciate the grief both in the disease as well as in the mourning that follows the death. At all levels of the experience, grief can be disenfranchised by the shame, secrecy, and stigma that are companions of Alzheimer's disease (cf. Kenneth Doka). In our concepts of identity, in the professional care settings as well as in our communities, we need to enfranchise this grief by developing attitudes and discussing strategies that can be used to support and validate all the grief throughout the course of the disease. We have to focus on a dementia friendly culture.

PS 10.2

What is the effectiveness of bereavement support and counselling?

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During the past decade research has been increasingly focused on the subject of grief, results concerning the effectiveness of bereavement counselling (BC), however, vary. Some theories question the effectiveness of bereavement support and others hypothise that everything is of help as long as the relationship between the bereaved and their counsellors is a good one.
What is meant by „helping a grieving person"? Freund´s demand to work efficiently on the target of „leaving behind the deceased and detaching oneself from the feelings connected with him", has long overcome.
Also, helping does not mean perfect symptom control within a certain time frame, based on the idea of a supposedly objectively defined half-life of symptoms such as sleeping disorders, tensions, lack of concentration, intense longing or dejectedness. Were these the goals and ambitions of BC, or the expectations of the bereaved themselves, it can be justifiably stated that BC is not able to achieve this.
A representative, non-clinical study including 73 individuals mourning a close relation's death carried out by ALPHA Rheinland between 2001 and 2003 found that BC caused a change, namely affecting a person's attitude and belief system, their self-esteem and self-respect.
According to oral and handwritten statements, 60 % stressed that BC enabled them to identify and, so to speak, comprehend their own grief reactions (sense of comprehensibility). 48% learned to manage their grief (sense of manageability) and 61 % became aware of how their grief reflected the meaningfulness of their relationship to and their love for the deceased (sense of meaningfulness).
Consequently, BC strengthened the bereaved persons' coherence and resilience. These coping resources are recognised as an individual disposition that contributes to advancement and maintenance of health.

PS 10.3

Obstructed grief following traumatic loss - a possible role for ritual

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In this paper I will present the case of a young woman who gave birth to four stillborn babies (quads). The extent of her loss was not acknowledged by the professional staff involved in her care, or subsequently by her husband. She was prevented from seeing the babies post delivery and from arranging a suitable funeral. Over the following six years she was unable to grieve and had to take time off work because of recurring mental health problems. Eventually she was admitted to a psychiatric unit following several attempts to commit suicide. A referral was made to the unit chaplain/ grief therapist. In partnership with the psychiatric team the chaplain worked to 'unblock' the grief process, and begin the process of healing, by devising an approprite ritual which was incorporated into the therapeutic task. Gradually this young woman ceased to be a high suicide risk, began a more natural grieving process, was discharged home and subsequently returned to work. This case history illustrates the importance of health professionals not assuming they know the value of another's loss and of not being over-protective of the patient/client or of their own reactions to trauma. Staff must ensure that appropriate assessment is made of bereavement needs in palliative care and other aspects of health care.

PS 12 Education and Training

PS 12.2

The evolution of E learning in palliative care education

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This presentation will look at the evolution of E learning in palliative care education and its emergence in recent years as a major educational tool. Examples of successful initiatives in E learning will be cited and discussed along with current research evaluating the impact of these initiatives. The benefits and current limitations of E learning will be discussed and the presentation will conclude with a speculative look at what the technological developments in this area have to offer palliative care education in the near future.
Reference: Becker R (2009) Online courses for nurses working in palliative care, European Journal of Palliative Care,16(2) 94-97

PS 12.4

Education in Palliative Care; the intercultural challenge

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Palliative Care's date of birth is assumed to be 1967, with the founding of St. Christopher's. Placed within the general changes taking place at the end of the sixties in the western world, we see however at least two parallel developments: a revolutionary concept of caring for dying people, and secondly, radical changes taking place in education. PC moves to place the "unit of care" in the centre; education, in a similar radical shift, places the learning person(s) in the centre. Introducing these parallel changes within a sociological matrix of change, we can see how the values and insights emerging also create a danger to enact a new kind of patriarchy today, or, via export, a new kind of imperialism.
PC traditionally defines itself as based on 4 pillars: medicine, nursing, psychosocial and spiritual. At the bedside and in education, it is enacted via multi-disciplinarity, and multi-professionalism. Importantly, the WHO definition (2002) also requires multi-centeredness: "patient and family."
It will be proposed here to acknowledge the "forgotten 5th pillar of PC": the discipline of education. It would allow to harvest from professionally informed attention to teaching and learning. This takes place constantly in PC: Between a patient and his/her family, between the representatives of the caring system on the one hand and the patient or his/her system, on the other. Cicely Saunders herself used new teaching techniques already very early on, be it most probably not based in the educational shifts, happening at the same time....
Multi-centeredness taken seriously, at least in education, invites multiculturalism, not only when someone from another culture is cared for in a western-oriented society, but also in exporting Palliative Care via education to other cultures.
Some examples on the educational developments for the Liverpool Care Pathway, will be used to illustrate the above.

PS 13 Clinical decision making around ethics – exploring the difficulties

PS 13.1

The ethics of non-treatment decisions (NTDs)

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Not initiating (withholding) or discontinuing (withdrawing) futile treatment are both "non-

treatment decisions" (NTDs). A commonly accepted definition of "futile treatment" is given. The area of NTDs is however wider than that of futile treatment since it includes situations in which treatment is effective but is considered disproportionate. From an ethical point of view, the latter is not unproblematic and some examples are provided. But nor is so-called futile treatment ethically unproblematic, even though it is regularly thought to be. One issue is whether futile treatment can ever be justified and this paper argues that it can. Recently, the notion of "palliative futility" has been introduced. In this presentation, this concept is rejected as a misnomer and it is also shown that it fails to mirror clinical reality. Other issues addressed are: Do physicians intend death when carrying out NTDs, or do they merely wish for death to come sooner rather than later? What is the difference, if any, between an intention and a wish? There is a practical-clinical difference between euthanasia (lethal injection by a doctor at the patient's voluntary and competent request) and NTDs, yet the outcome (immediate death) may sometimes be similar. Does this factual difference also amount to an ethical difference? Is it, in the language of ethical theory, a difference that makes a difference or are both instances simply cases of medicalised killing albeit at different levels?

PS 13.2

Is palliative/terminal sedation just ´slow euthanasia´? an alternative to euthanasia? or something totally different from euthanasia?

Griffiths J[1]
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Palliative/terminal sedation has been welcomed by some as an ethically and legally unproblematic alternative that makes euthanasia (and physician-assisted suicide) unnecessary. It has been criticized by others as ´slow euthanasia´ without the legal safeguards, and which - if in effect imposed on patients who would have preferred euthanasia - deprives them of a significant part of the control over the time and manner of dying that euthanasia offers. To assess such claims, some fundamental distinctions must be drawn between palliative sedation, terminal sedation, and euthanasia. The legal status of all three must be examined with more precision than is usually evidenced. The dangers associated with each of them must be specified. And the possibilities of adequate control must be assessed.

PS 13.3

End-of-life decision making in clinical-ethical case consultation at a university hospital

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45% of all clinical-ethical case consultations between 2006 and 2008 (n=67) were related to end-of-life issues. 21% concerned withholding / withdrawing treatment at the intensive care unit, 7% withholding / withdrawing treatment at the general hospital ward. 7% concerned patients asking for assisted suicide, 3% the question of whether or not to attempt resuscitation, and another 3% the interpretation of an advance directive. Some specific cases are discussed.
But not only in terms of the subject to deal with there is a close affinity of clinical ethics to palliative care. Both disciplines use an integral, interdisciplinary approach, trying to reconcile of the realm of scientific medical evidence, and the realm of individual values of patients and caregivers. In doing so, both palliative care and clinical ethics run counter to the organisational logic of a hospital, and a university hospital in particular, where the institutional power follows the scale of organ-specific specialisation or specialised technical intervention. This is one explanation why both disciplines, no matter how much they might be needed by patients and their caregivers, are often marginalised within these institutions.

PS 13.4

The UK mental capacity act - implications for Palliative Care

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The UK Mental Capacity Act 2005 governs how decisions are made on behalf of patients who lack capacity to take those decisions for themselves. It has ethical implications for palliative care. Whatever decision is made must be made on the basis of the 'best interests' of the patient. The best interests judgement must be based on all the relevant clinical circumstances (including benefits, harms and risks of treatments) and whatever can be known of the patient' wishes, feelings, beliefs and values. Any written statements made by the patient must be considered, but the decision is based on best interests and not just on the patient's advance statement of preferences. The decision must be based on the interests of the patient only, not those of the patient's family (contrast with the philosophy of palliative care). This is ethically important. The law enables patients (with capacity) to make a refusal of a specific treatment in advance of loss of capacity. But the responsibility for deciding whether the advance refusal is valid, and truly applicable in the circumstances is given to health care professionals. This is ethically difficult because the patient is enabled to make an advance 'choice' but much of the responsibility for that choice is then passed to health care professionals. There are other ethical implications of Advance Care Planning/Advance Statements, e.g. patients must be adequately informed when they are asked to express preferences about their treatment and care for a future time when capacity is lost. The Mental Capacity Act is designed to uphold and protect the interests of the patient who lacks capacity. But major ethical problems arise where the interests of the patient who lacks capacity conflict with the interests of their family, or with the interests of other patients, and where pursuing the interests of the patient lacking capacity conflicts with the important values of equity and cost effectiveness in a publically funded health care system.

PS 14 Team-working & conflict management

PS 14.1

Are teams the best way to provide palliative care?

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Teamwork can be fulfilling or frustrating and, in many parts of the world, expensive. When the late Dame Cicely Saunders developed her 'Total Pain' model (Clarke 1999) it became clear that such an holistic approach would be difficult to deliver by a single profession. Over the past 40 years a variety of team approaches to care delivery have been developed across the palliative care world. There is an assumption that the best quality palliative care is delivered through a teamwork approach (A First Class Service 1998, the NICE Guidance 2004 and Hearn & Higginson 1998). Poulton and West (1999) showed that team processes accounted for 23% of the variation between teams in their effectiveness. Many teams find it difficult to attend to ´process´ and this can lead to frustration and tension. However, there is still limited research to show if such team approaches are the most effective way of delivering care. This paper will examine some of the arguments for and against team-working and the need for further research into this fundamental tenet of the palliative care philosophy. Clarke D (1999) 'Total Pain', disciplinary power and the body in the work of Cicely Saunders 1958-1967. Social Science & Medicine 49, 727-736. Dept of Health UK (1998) A First Class Service, Quality in the New NHS. NICE (2004) www.nice.org Hearn and Higginson (1998) Do specialist palliative care teams improve outcomes for cancer patients? A systematic review. Palliative Medicine. 12, 317-332. Poulton and West (1999) The determinants of effectiveness in primary health care teams. J.of Interprofessional Care 13(1) 7-18.

PS 14.2

The interdisciplinary team

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The team approach is an inherent component of palliative care and included in the 2002 WHO definition. A team is different from a group or a crew. An interdisciplinary team is an identified collective in which members share common team goals and work interdependently in planning, problem solving, decision-making, and implementing and evaluating team-related tasks. The team is characterized by a high degree of co-operation and communication, and professional, task-centred leadership which varies from case to case depending of the needs of the individual patient and family. The following categories distinguish effective teams: communication, cohesion, mutual respect, goals, purpose, and leadership.
To be a team, the team members need to be defined. This is vital for the communication and collaboration within the team, but also for the organisation served by the team. Membership defines the team's boundaries. The most common membership distinction is between the core team and the extended team. Core members are usually full time members governed by the team policy and managed by the team leader. Extended team members are usually part-time in the team, not governed by team policy, and having managers outside the team, with less voting rights on team decisions. This may give rise to tensions.
While efficient teamwork demands a defined team, palliative care also needs to be flexible. Ideally, the team should be tailored to suit the needs of the patient and family in each individual case. However, although flexibility is needed, loose team boundaries may lead to drifting team members working multidisciplinary instead of interdisciplinary.

PS 14.3

Clinical supervision and reflective practice

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Background: Increasingly organisations which offer palliative care are being required to set up supervision systems.Government End of Life initiatives particularly in the UK are being asked to employ staff with a range of skills and competencies which can be demonstrable. There is recognition that clinical supervision, case level management and reflective practice are all different but with similarities.Some palliative care practioners require supervision for their registration but as yet it is a relatively new concept for the nursing and medical professions.
Method: This presentation will examine some definitions which will be explored using clinical examples. It will also discuss the merits of supervision in helping people stay happy and healthy in their roles. The author will describe the setting up a clinical supervision system for all staff in a UK Hospice. This will include survey results and the planning of educational initiatives. The author will give examples from her own experience both in receiving regular supervision and having been a clinical supervisor for 20 years
Conclusions: Clinical Supervision and reflective practice is an extremely important part of palliative care. It helps workers stay focussed on the task and is vital in improving the skills competencies and their wellbeing.Increasingly we are looking to provde training for supervisors but where will this come from and what sort of supervision is requiired

PS 14.4

Conflict management

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Caregivers in palliative care units underly some framing conditions which can make conflict management complicated, for example non-hierarchical decision making in hierarchical medical settings. When conflicts between team members lead to frustration and loss of efficiency, counselling may be a helpful antidote. Methods of conflict management provide several strategies in solving problems. These strategies are quite similar to basic elements of communication with palliative patients like listening and the expression of feeling. However, the experience shows, that team dynamics such as the competition for ressources, social rank and position in the team do not always make it easy to follow the measures as advised. Therefore an analysis of required competencies for team members is made referring to a theoretical model of team development. Related questions will be discussed from a systemic point of view: What are the (hidden) barriers to become effectively? How can palliative care teams use conflicts to initiate development processes? Which useful function can conflicts have in palliative care teams? Inherent assumptions with respect to dealing

with conflicts will be derived. Herein, the basic premises are to gather information and to identify the type of conflict. The main instruments to resolve are negotiation and mediation. Finally, the role of the counsellor will be explicated.

PS 15 Palliative care peer-reviewed journals: the editors tell all

PS 15.2

Journal of Palliative Medicine

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The Journal of Palliative Medicine serves the interdisciplinary field of palliative care. The first volume was published in 1988. David Weissman, MD was the founding editor. Manuscripts are selected with the understanding that the vast majority of readers are clinicians. Opportunities to publish at various stages of career and levels of evidence exist within the structure of the journal. While initially serving authors and readers in North America, both readership and authorship have now become global.

PS 15.4

Palliative care peer-reviewed journals: The editors tell all

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The aim of this session is to provide an opportunity for the editors of some leading peer-reviewed journals to provide information about the scope of their journal and details of their working practices. The editors will describe what happens to manuscripts which are submitted, how many people read the paper and who they are, how decisions are made about which papers are sent for external review, how referees are selected for each paper and who they are, what happens to referees reports and who makes the final decision about publication. Information about referees, who they are and where they are based, becoming a referee and maintaining a place on the referees database.
The editors will also present information about the number of manuscripts received, the proportion accepted and rejected, the time taken to process each manuscript, from receipt to final acceptance or rejection, and the time from final acceptance to publication. In order to give an indication of the type of papers published each editor will indicate the top 10 cited papers from his journal over the past year and five years. Other topics to be covered will be impact factors and how they are calculated, impact factors and academic careers, the number of palliative care peer-reviewed journals and whether there are too many and what the future holds: peer-reviewed journals in 10 years time.

PS 16 Spirituality - an issue for palliative care

PS 16.1

Spiritual care in palliative care - blessing or curse?

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NICE Guidance for Supportive Care (UK 2004) and peer reviewed papers in journals reflect a growing requirement for spiritual care to be assessed and provided within palliative care, as well as other health care settings. There is also a growing evidence base to indicate that spiritual and existential issues are important for patients, whether or not expressed through a formalised religion. The importance of religious belief and practice has also been demonstrated to have a role in the coping strategies of people facing life-threatening disease (Koffman 2008, Pargament 1997). Many attempts have been made to create assessment tools or systematise the discernment of spiritual need. Gordon and Mitchell (2004) have proposed a competency model for assessment of spiritual care, while Daaleman et al (2008) in examining the understanding of clinicians and other health care workers have recognised the highly fluid nature of the interaction between spiritual care-giver and patient.Insensitive and/or inadequate approaches to assessment or provision can prove harmful and highlight the need for careful exploration with awareness of the dangers of acting on assumptions. Minimising risk of harm requires a more than basic level of communication skills and a willingness to reflect on one's own beliefs, values and ability to work with difference. In this way the provision of spiritual care may prove to be more a blessing than a curse.
NICE Guidance (2004) www.nice.org
Koffman J et al (2008) "I know he controls cancer": The meanings of religion among Black Caribbean and White British patients with advanced cancer. Social Science & Medicine 67, 780-789.
Pargament K (1997) The Psychology of Religion and Coping Guilford Press, London. Gordon & Mitchell(2004) A competency model for the assessment and delivery of spiritual care. Palliative Medicine 18(7), 646-651.
Daaleman (2008) An exploratory study of spiritual care at the end of life. Annals of Family Medicine 6(5), 406-411.

PS 16.2

Spirituality in palliative care: a clinician´s perspective

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Spirituality in the dying is a difficult area for many: the spirit is a dimension so rich in shades, with so many and so varied facets, so vivid in its manifestations, that it makes it necessary to approach its study with the ingenuity of someone who is about to enter a completely new and unknown world.Palliative Care clinicians must always be aware that the main objective of their professional work is to alleviate suffering. This will mean acknowledging and addressing pain in all its dimensions and striving to achieve a degree of competence to deal with it at some level.
The spiritual dimension manifests itself through questions such as "Why me?", "What happens when I die?", "Is there meaning in life?" and is often ignored by clinicians fearful of making things worse. In other occasions their training and skills don't equip them to be able to suspect 'total pain', let alone deal with it. The dying are left on their own to identify, develop or reaffirm sources of spiritual energy and in -so doing- foster hope. Many are too vulnerable to do so without help. Acceptance of self - despite regrets for past events or behaviours; granting and accepting forgiveness; finding opportunity to express guilt or blame; finding the strength to address the present: Why me?, low self-esteem, change in body image, change in role within family; feelings of isolation and anger; and dealing with the future: fear of dying, leaving loved ones, finishing business....Are painful but relevant matters in a life coming to its end. All may need our help to come to the surface and be dealt with in an assertive manner by the patient, their families and ourselves.
A clinician is certainly more confident when dealing with signs, symptoms, clinical manifestations and treatments, etc than with more abstract and difficult to define issues.
This piece of work aims to present the topic in a way that might empower all healthcare professionals to help patients negotiate difficult issues.

PS 17 Complexity in Symptom Management

PS 17.1

What is the difference between complex and complicated symptom management?

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Palliative Care professionals are often confronted with complex symptoms, even suffering from different origin, and find any symptom management as being complicated and difficult. If symptoms are complex, the concept of "total" (pain) may be used which signals a far more complicated and usually longer process for getting it better, and a rather pessimistic prognosis (e.g. cancer pain staging system). There is no common definition of what is complex, but complexity is not a phenomena limited to Palliative Care but has parallels in physical, biological and social systems (Munday et al 2003). Interactions and evolution of phenomena are not predictable, non- linear, and may end in chaos in complex systems (the "butterfly effect" has been known for years). Any individual may be an example for such a complex system and any reductionism in terms of standardized assessment or drug regimen seems to be hopelessly naive.
"Complicated" is different from complex in terms of stability and predictability of interactions. Multidimensional assessments and interventions are therefore used for creating a better understanding of the involved factors and for getting better results in the treatment of complex symptoms. A good example is the diagnosis and treatment of chronic pain which is based on solid knowledge from different fields in science. The interconnections within the pain regulatory system are best described as being 'complicated', but we are still far away from providing an understanding for its possibly 'complex' character.
In a case based approach the challenges for using a reductionistic concept for dealing with complex systems will be highlighted. There might be a truth beyond the concept of 'evidence'.

PS 17.2

Opioid induced hyperalgesia and paradoxical pain

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Opioid therapy is associated with a number of well-known adverse effects as cognitive impairment, bowel dysfunction, dryness of the mouth and urinary retention, but also with development of tolerance and opioid-induced hyperalgesia (OIH). OIH is broadly defined as a state of nociceptive sensitization caused by exposure to opioids. Decreased effectiveness of the opioid therapy raises the difficult question, whether it is a sign of tolerance development, OIH, progression of tissue injury or a combination of these factors. OIH was primarily described in patients with advanced cancer receiving high doses of opioids for prolonged periods (1). However, recent studies indicate that OIH are much more prevalent and it has been described in former addicts in methadone maintenance (2), during perioperative exposure to opioids (3) and in chronic non-cancer patients treated with opioids (4). The mechanisms behind development of OIH are not known, but recently a study in chronic pain patients treated with opioids demonstrated a less efficient activity in the pain inhibiting diffuse noxious inhibitory control system (5).
1) Sjøgren P, Jonsson T, Jensen NH, et al. Hyperalgesia and myoclonus in terminal cancer patients treated with continuous intravenous morphine. Pain 55: 93-97, 1993.
2) Doverty M, White JM, Somogyi AA, et al. Hyperalgesic responses in methadone maintenace patients. Pain 90: 91-96, 2001.
3) Guignard B, Bossard AE, Coste C, et al. Acute opioid tolerance: intraoperative remifentanil increases postoperative pain and morphine requirement. Anesthesiology 93: 409-417, 2000.
4) Chu LF, Clark DJ, Angst MS. Opioid tolerance and hyperalgesia in chronic pain patients after one month of oral morphine therapy: a preliminary prospective study. J Pain 7: 43-48, 2006.
5) Ram KC, Eisenberg E, Haddad M, et al. Oral opioid use alters DNIC but not cold pain perception in patients with chronic pain - new perspective of opioid-induced hyperalgesia. Pain 139: 431-438, 2008.

PS 17.4

Symptom management for patients with end stage renal disease and palliative care patients with renal impairment

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Renal impairment (RI) is common among palliative care patients who may develop acute renal failure, a gradual decline in function or have End Stage Kidney Disease (ESKD) all of which situations will impact on drug handling and toxicity and hence our management of their symptoms.

Many drugs and their metabolites are excreted through the kidney; accumulation of the drug or its active metabolite (the most important function affected) will contribute to an already narrow therapeutic window of benefit versus toxicity, though other aspects of drug handling are also affected.
Caution is needed when using guidelines for drugs in RI as recommendations are usually based on single dose studies based on creatinine clearance and not the chronic dosing needed in palliative care or estimated GFRs used by many clinicians and which are least accurate at the extremes of life or body habitus.
50% of ESKD patients experience moderate or severe pain in addition to a high non pain symptom burden; (mean of 9 symptoms in one study of elderly dialysis population). The incidence of the most common symptoms are dry skin, fatigue, pruritus, anorexia and sleep disturbance is 72, 70, 55, 49 and 42% respectively with almost all patients experiencing a dry mouth.
Management of pain, with special reference to strong opioids will be discussed. Careful assessment, explanation, individual titration with normal release preparations at an increased dosing interval of drugs with inactive metabolites; close monitoring for relief and toxicity and the use of adjuvants all contribute to improved pain control.
Management of other symptoms, in ESKD, will depend on the symptom, stage of disease, its severity and other symptoms that may be worsened by side effects from newly introduced drugs or improved by drugs which may also help more than one symptom. Thus the clinician needs to know the range of possible interventions and choose the one that is most effective in the particular clinical situation

PS 18 Palliative care as a public health issue

PS 18.1

Why palliative care is a public health issue

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In recent years there has been considerable interest in promoting the idea that palliative care is a public health issue. Indeed it is often claimed that palliative care should be integrated into public health systems and become part of mainstream healthcare provision. But this is only one aspect of 'public health', more broadly defined. In this session I shall explore the different meanings of 'public health' – from epidemiology to citizen participation – and assess their relevance to palliative and end of life care. I shall warn against too narrow a definition of 'public health' when considering end of life issues. Such a perspective could fail to capture the wider potentialities that exist in communities, in 'social capital' and in the many other stakeholders with a concern about how society cares for its most sick and vulnerable members.

PS 18.2

The process and preliminary outcomes of a European Parliament report on palliative care

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Following the publication of a final independent report for the European Parliament (EP), entitled Palliative care in the European Union, it could be of interest to reflect upon the process and the outcomes we observe nearly a year after its official dissemination. The report arises from the EP´s desire to assess palliative care from a public health perspective, although many key stakeholders in the palliative care field also contributed to its elaboration, including the EAPC, a number of palliative care experts, national palliative care associations, and national health authorities. The challenge was to transform the solid research evidence gathered into a range of operational policy options for MEPs, using a broad public health-based approach which sees palliative care as the last and vital link in the community healthcare chain. Although the European Parliament has not yet considered the findings formally, we believe that the document still represents a powerful tool for advocacy and a source of operative information for policy-makers.

PS 18.3

Potential cost savings of greater use of home and hospIce-based end of life care in England

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Aim: RAND EUROPE was commissioned by, and worked with the National Audit Office (NAO) to estimate the financial consequences of decreasing the reliance on acute hospital care during the last year of life by expanding home and hospice-based care. This commissioned study is part of a broader Value for Money study that the NAO is undertaking into end-of-life care in England.
Methods: We developed an economic model (a Markov model), which uses the latest disease statistics, health expenditures and utilisation data available. We ran the model to first estimate the current cost (to the NHS) of health care provision of end-of-life care for patients who are in their last year of their life and suffer from cancer or organ failure (pulmonary and heart failure). Then, we used the model to simulate various scenarios of decreasing reliance and usage (over this period) of acute care by those patients and estimate the economic implications to the health system. The implicit assumption is that the number of unplanned emergency admissions and the length of stay in the hospital could be reduced by providing end of life care in the community and in hospice. We estimate the days of acute care which could be avoided and the amount of resources which could be made available for redeployment.
Results: Results suggest the potential of substantial amount of resources that could be released by decreasing reliance on acute care in England. Due to parliamentary privilege results can not be disclosed prior to the publication of the full National Audit Office Report to Parliament in November 2008.
Conclusion: This study contributes to the scant economic literature on the economics of palliative care. It demonstrates the benefits of increasing the reach of palliative care services; it shows the potential of releasing substantial amounts of resources which could be used to better meet patients wishes of avoiding being cared for in an acute setting as they approach the end of life.

PS 19 Palliative Nursing

PS 19.1

What do we mean by palliative nursing?

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Nurses and nursing as a profession are keen to highlight their contribution to the care of patients in the palliative phase of illness, and to explore and explain what differentiates nursing care from care given by other healthcare professionals. This presentation highlights aspects of these issues, focusing on the care nurses give in the patients own home, and on the interface between the care given by nurses who specialise in the provision of palliative care, and those who do not.
In the UK, as elsewhere, there is a real drive for care to be delivered at home, and where possible and desired, for patients to die at home. Nursing care is seen as important in achieving these goals. Research exploring the roles of generalist and specialist palliative care nurses providing home care will be reviewed and discussed. The different perspectives of the nurses themselves and the patients and family carers for whom they care will be debated. Research exploring the way that generalist and specialist nurses work together will also be presented to assess how such inter-nurse relationships impact on palliative care at home.
Conclusions will be drawn from the evidence presented to illuminate what palliative nursing care at home means to nurses and patients, and to explore how to provide high quality nursing care at home. The implications of this for the role of home care nurses, the theoretical development of palliative care nursing, and the way that nurses are prepared for practice will be discussed, with reference to EAPC guidance on palliative nurse education.

PS 19.2

Translation and validation of the esas (edmonton symptom assessment scale) in Spanish

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The aim of this communication is to introduce the process of translation and validation of the Spanish version of the ESAS, in addition to further studies generated by them. The translation process was obtained using a reverse translation method by bilingual translators, a method recommended by experts when cross-cultural studies are undertaken. After obtaining a Spanish version of the ESAS, it was found that screening by means of numerical scales for anxiety and depression and also fatigue, needed clarification of the terms chosen. Two prospective studies were then designed to study this.
After this preliminary process, the validation study was carried out. Internal consistency was measured by means of Cronbach´s Alpha, obtaining a coefficient of 0.75. The test-retest was performed by Spearman's correlation obtaining a rate from 0.65 to 0.94. Factor analysis obtained satisfactory results. Concurrent validity of the ESAS with the Rotterdam Symptom Check List obtained a correlation from 0.55 to 0.76. Discriminant validity was measured in different functional states with the Kruskal-Wallis test and a significant difference ($p<0.005$) was found between groups. The responsiveness was measured using the Wilcoxon test for the ESAS on days 0 and 2, where a significant difference ($p<0.05$) was found for the majority of symptoms.
The next step was to design an implementation process in the Oncology department of our University Hospital. An Electronic ESAS database was available on the centre's computer network. After three years of systematic symptom evaluation we carried out an audit process between nurses and physicians as to the systematic use of the instrument. At this time we are finalising analysis of this audit.
Further studies will be a retrospective study to analyse the data for 400 patients registered on the ESAS database. A new prospective study of the prognostic value of the ESAS and the development of ESAS guidelines through an international Delphi process.

PS 19.3

Palliative Nursing: An African Viewpoint

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Despite the significant need for palliative care in Africa to address its high burden of disease (especially cancer and HIV/AIDS), palliative care remains a new discipline and therefore in some countries it is reasonably well established and almost nonexistent in others. Provision of palliative care across Africa is largely spearheaded by nurses given their availability at all level of care. Nurses therefore play a pivotal role in palliative care development in the region and this unique position provides them opportunities to shape and guide the development of palliative care in Africa.
Nurses are therefore at the forefront of the integration of palliative care into all levels of care so that everyone in need of palliative care has access to it - although reaching this aim is still a long way off. Despite this, however, nurses all over Africa are emphasising the need for palliative care programmes that are affordable, culturally appropriate and available to both children and adults, with the proviso that as palliative care service provision is extended, the quality of the care offered is maintained. This presentation will provide a brief overview of the key aspects of the nurse's role in palliative care development before outlining the challenges they face in this role and ways in which these challenges have been addressed across Africa, emphasising the need to embrace the public health approach to palliative care in Africa.

PS 19.4

Palliative Care Nursing: an Australian reflection

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Care of the dying has been part of the Australian healthcare system since the early days of our colonisation. The religious orders, who came to Australia to establish hospitals among other activities, saw care of the dying as central to their work. Large traditional hospices were developed alongside the hospitals and have remained a core inpatient service to this day. In the last 30 years or so, alongside developments in medical technology, more active care systems for those facing the end of life have emerged, particularly in home-based care.
Palliative care services have taken on of care of the whole person (not just the clinical course of the disease or their physical care) and emphasise the centrality of the person themselves being involved in the decision-making about care. Palliative care expertise is now widely available in many settings - at home, in acute hospitals, in aged care settings and specialist in-patient palliative care units, sometimes still called hospices. However, palliative care is still finding its place within healthcare systems; and there are many different models and approaches to the delivery of palliative care evident across the country. This paper addresses the contemporary requirements to utilize both primary health and health promotion principles and policies to disseminate the expertise of palliative care as widely as possible.

PS 20 EPCRC – Cancer cachexia in the palliative care context

PS 20.1

Current concepts of classification and genetic markers of cancer cachexia

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Cancer cachexia is a multi-factorial syndrome that encompasses a spectrum from early weight loss (pre-cachexia) to a state of severe incapacity incompatible with life. There is currently no 'all inclusive' definition that encompasses the entire spectrum of cachexia. A multi-dimensional classification of the cachetic state may be more useful in terms of clinical outcomes. Key defining features of the syndrome such as weight loss, systemic inflammation, decreased nutritional intake and low fat-free mass index may provide a possible framework for classification.
The molecular mechanisms of cancer cachexia include:
i) host- tumour cell interaction leading to an initiation of host inflammatory response,
ii) hypertrophy/atrophy pathways that govern muscle-wasting,
iii) adipose turnover pathways that regulate lipolysis, and
iv) activation/deactivation of neurohormonal pathways controlling appetite.
The wealth of known polymorphisms in genes involved in the above mechanisms suggest their exploitable potential as biomarkers of inter-individual predictability of developing cachexia. To illustrate this, polymorphisms in pro and anti-inflammatory cytokine genes have been associated with accelerated weight loss in patients with gastro-intestinal cancers in recently published articles.
The European Palliative Care Research Collaborative (EPCRC) is committed towards developing symptom assessment and classification for cancer cachexia (WP 2.3) as well as identifying genetic markers of cancer cachexia (WP 1.2).

PS 20.2

How will the current classification work influence assessment and management in clinical daily care in the cancer disease trajectory

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Accepted current definitions of cachexia: use weight loss (5% in 6 months) or Body Mass Index (< 18.5) for diagnosis, but with these definitions a lot of cachexia seems to be missed. This often leads to late diagnosis of cancer-related cachexia, when weight loss is evident. However, for far advanced and severe cachexia treatment is often futile. Nutritional therapy is often not effective with catabolic metabolism, and a review of the evidence base leaves few options for effective and tolerable drug treatment.
Diagnosis of cachexia in earlier stages as well as identification of patients at risk for developing cachexia is needed. Initially cachexia may lead to loss of muscle mass, but body weight may still be normal. More specifically, obese patients often may have lost a lot of muscle mass before cachexia is diagnosed, and early identification could lead to prophylactic and therapeutic approaches preventing cachexia.
However, this requires matching effective treatment approaches with the classification system. The new classification system and effective treatment regimens have to be processed into clinical guidelines.
Implementation of these guidelines in clinical practice is not self-fulfilling, and requires specific care and dedicated resources. For clinical practice, pathways may be useful, including screening steps for early identification of patients who are at high risk of developing cachexia or are in early stages of weight loss, as well as classification and differential diagnosis, and from there to treatment algorithms and outcome control. Audit or other quality assurance measures can be used to monitor the implementation process.
Feeding the classification work into the guideline development process, the new classification may seem to complicate matters at first, but ultimately will help to provide a differentiated therapeutic approach for many patients with cancer-related cachexia who until now are not treated adequately.

PS 20.3

Is assessment of physical function a surrogate of muscle strength and finally patient´s quality of life?

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Physical function (PF) deteriorates in most advanced cancer patients as the disease progresses. Decline may be even more pronounced in patients with cachexia and is associated with muscle wasting, fatigue and reduced activity level. PF is a multifaceted construct that might be assessed by a variety of methods targeting different aspects of PF. In order to develop feasible and valid assessments, consensus on which aspects of PF that is relevant in advanced cancer patients is essential. Different instruments, tests and methods give different information about patients' function in everyday life. PF is typically assessed by self-report instruments like the physical dimension of quality of life questionnaires. Such instruments see PF as a single dimension although it includes many of aspects of functioning. In cancer cachexia, measures like muscle strength may reflect muscle wasting and provide information about the muscular aspects of PF. Additional tests are required to get a balanced picture of PF, including objective measures of functional capacity, performance and every day life activity. A better understanding of the component parts of PF is needed to develop assessment tools that can be used to assess patients from very low to high functioning and to measure change through disease progression and following interventions. The WHO International Classification of Function, Disability and Health provides a useful framework for classifying aspects of PF and two dimensions has been found to be of specific relevance for palliative cancer patients; self care and mobility. Physical activity level and pattern (which may be measured with an activity monitor) is closely related to PF and is another important aspect to include in the assessment. PF is an important part of quality of life in patients with advanced cancer. However, it is yet an open question as to which aspects of PF and what outcome measures are the most valid as functional end-points in palliative care.

PS 20.4

Diagnosing and treating cachexia-related suffering of patients and family members with advanced cancer

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Suffering from cachexia in advanced cancer patients may be underestimated: It encompasses its psychosocial **consequences** (eating-related distress [ERD], patients & family), cachexia-related fatigue, depression, dyspnea, early satiety or anorexia. On the contrary, suffering (e.g., pain, vomiting, depression, constipation) can be a **cause** - not a consequence - of cachexia, these symptoms can be conceptualized as **Secondary Nutrition Impact Symptoms** (S-NIS).
ERD, a "negative emotional experience in consequence of change in eating habits", is related to the perception of decreased muscle mass, physical fatigue or weight loss and often exacerbated by family pressure. In the EPCRC "cachexia definition, diagnosis and classification Delphi process" the experts agreed substantially, that the psychosocial impact of cachexia should be assessed (e.g., "have you experienced feelings of pressure, guilt or relational distress related to WL?").
To diagnose cachexia-related suffering EPCRC is developing a **staging system for cancer cachexia in the Palliative Cancer Care context** [PCC-C]. It will include not only all relevant elements of a practice-guiding assessment tool (energy & protein storage, intake [incl. S-NIS], catabolic drive [inflammation, tumor dynamics], muscle & physical function), but also an estimate of the individual impact of cachexia. The definition of late, irreversible cachexia, but also of early or pre-cachexia, may guide clinical practice.
To perform effective **interventions for cachexia-related suffering**, standard Palliative Cancer Care assessments (symptom load, emotional and existential distress, information status, cooping patterns, life goals and priorities, family interactions) and basic interventions (pharmacological, educational, counseling [two-sided Calman-Gap]) need to be addressed. Then cachexia-staging driven specific interventions tackling defined goals are provided by teams, **EPCRC is developing guidelines** for cachexia management in the PCC-C.

PS 21 EPCRC - Depression in palliative care - challenges and new knowledge

PS 21.2

Conceptualisation by professionals of depression in palliative care Findings from the EPCRC-projects

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Background: The diagnosis of Major depression within palliative care clinic and research is complicated by factors such as variations and lack of consensus on assessment and classification of depression. Another is the overlap between depressive symptoms and symptoms of disease/treatment. Therefore, experts on depression were asked to evaluate symptoms and items of potential relevance for the diagnostic criteria.
Methods: This study is part of The European Palliative Care Research Collaborative (EPCRC), which is working towards common methods for assessment and classification of depression as well as for pain and cachexia. As part of the EPCRC, an expert panel was established. Seven qualified researchers from Japan, Canada, the United Kingdom, Austria, Italy and Norway participated. The panel included psychiatrists, physicians and a clinical psychologist, all with long experience in Palliative care practice/research and related areas such as oncology and psychiatry. The expert group was presented with symptoms and items on depression, retrieved from assessment methods or classifications systems collected in a systematic literature review. The relevance for the diagnostic criteria of each symptom was then determined. In addition, the experts grouped items in accordance with these symptoms. The Delphi method was applied.
Results: Depressed mood, anhedonia, feelings of worthlessness and recurrent thoughts of death were considered the most relevant criteria for establishing a diagnosis of Major depression. Supplementary symptoms such as hopelessness were appraised as important. In contrast, significant changes in weight or appetite and fatigue were evaluated as less relevant. Other symptoms were proposed by individual experts and examined by the panel.

PS 21.3

Conceptualisation by professionals of depression in palliative care: Findings from the EPCRC-projects (WP 3.2)

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Background: In palliative care the diagnosis of depression is difficult because of problems differentiating normal and disordered distress. Moreover, the somatic symptoms of depression can mimic those of advanced illness, making it difficult todistinguish between depression symptoms and physical disease.
Purpose: The EPCRC is developing a clinical guideline for the management of depression in palliative care. An expert group was constituted to address management issues, and as part of this they were asked to identify clinical challenges in the conceptualisation of depression in palliative care.
Method: The 27 experts were from different countries, a wide range of disciplines (palliative care, psychology, psychiatry and general practice) and settings (home, hospital, hospice). A number had undertaken research into detecting and treating depression in palliative care. They identified challenges and commented upon clinical questions relating to conceptualisation of depression in palliative care. Responses were discussed during conference calls and circulated until there was no further feedback using a modified Delphi method.
Results: There was agreement that somatic symptoms are less useful in making a diagnosis in palliative care. In distinguishing depression from natural sadness, the experts emphasised three symptoms - anhedonia, hopelessness and suicidal ideation. Mood was considered more useful than function in assessing response. The utility of formal diagnoses was debated. Several argued that the detection of cases of depressive disorder according to diagnostic criteria may be less important than detection of depressive symptoms remediable to treatment.
Conclusions: Conceptual confusion impedes management of depression. Three mood related symptoms may be most useful in its detection. It may be useful to focus on treating depression symptoms. Cross-sectional studies are needed to determine the symptoms that best characterise depression in palliative care.

PS 22 Advocacy, a key activity for the development of hospice and palliative care

PS 22.1

Developing and implementing an advocacy strategy: The global perspective

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The purpose of this session is to highlight the importance of global level advocacy to tackle the barriers to hospice and palliative care service delivery at all levels. In addition, the session will look at the necessary components for the development and implementation of an effective advocacy strategy at any level.
The Worldwide Palliative Care Alliance advocacy group is a globally represented group who advocate for change to tackle barriers to hospice and palliative care at all levels and increase access to pain and symptom management. In addition, the group works to increase the advocacy capacity of hospice and palliative care organisations at the national level.
Key barriers to the development of hospice and palliative care were highlighted in the Korea declaration on palliative care in 2005 and since then the group has aimed to influence key global institutions, promote palliative care at relevant fora, develop advocacy partnerships and allies and develop advocacy resources to tackle these obstacles.
This session will look at the vital components of an advocacy strategy, the successes and challenges of advocacy at the global level and the importance of global advocacy for the improved provision of care for patients with life-limiting illnesses, their families and carers.

PS 22.2

Advocacy for hospice and palliative care in Africa: A regional perspective

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Palliative care in Africa is a relatively new concept. Although the first hospice program in Africa began way back in the late 1970's in Zimbabwe, such services have not been available in many parts of Africa. The need for palliative care in Africa is enormous as a result of the huge disease burden coupled with lack of resources in so many parts of the region.
Advocacy is recognized as a vital component in improving access to palliative care and in particular opioid medications in Africa. Promoting the availability of palliative care for all in need; encouraging governments across Africa to support affordable and appropriate palliative care and to have it incorporated into the whole spectrum of existing health care services; as well as the promotion of the availability of essential palliative care medicines (especially opioids) for all in need, are some of the African Palliative Care Association's advocacy strategic objectives.
Three innovative workshops for improving access to essential medications have been delivered by the African Palliative Care Association involving 18 countries throughout Africa. The aims of the workshops were to identify the barriers to palliative care and accessible opioid medications, to improve participants' knowledge of policy changes to make opioids available and to support the development of tangible action plans to facilitate change.
Following the advocacy workshops in the regions, there has been significant movement on drug availability in particular, and improved access to palliative care in general, in East, West and Southern Africa.
Advocacy at the regional level is playing a great role in improving access to palliative care in Africa, despite the many challenges.

PS 22.3

Advocacy success in Romania: A national and local perspective

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Palliative care in Romania started in 1992 as a movement in the NGO sector. Advocacy was structured around the elements of the WHO triangle (education, access to medication, service development and national strategy). Two consensus meetings with relevant stakeholders (Ministry of Health, college of doctors and nurses, university rectors, media) were organised in the late 90s and as a result palliative care was recognised in 2000 as a medical sub-specialty with a national unitary curriculum. Over 200 doctors have graduated the 18 months training and been awarded the palliative care diploma since then. Advocacy for changing legislation was another major task. Romania being in a transition period was helpful as legislation was adjusted to comply with European Union requirements. Palliative care provisions were included in the law concerning patients rights in 2001 and hospital law in 2003. In 2005 in the frame contract that governs the financing of the health system in Romania, provision for financing palliative care in-patient units were included. Change of opioid legislation was a lengthy process involving the governmental sector, NGOs and international experts. The challenging task continued with the process of the implementation of the law. Over 3500 doctors and pharmacists have been trained in two years in up-to-date pain management and opioid prescribing. The new law is now a model in the region and the process was copied in the Republic of Moldova. 2007 was the year when the service providers from NGOs and the public sector joined into a coalition. In 2008, a national awareness campaign was designed and run with minimal success as proved by the population surveys done pre and post campaign. But as a result the Ministry of Health signed the partnership with Hospice Casa Sperantei to develop the National Plan for Palliative Care. At the local level palliative care was introduced in the undergraduate curricula for the medical and nursing students.

PS 23 Global funding: an important issue for Hospice and Palliative Care

PS 23.1

Funding hospice and palliative care internationally: the funder's perspective

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The aim of the session is to review the current funding environment for hospice and palliative care and focus on the experience of the Open Society Institute as one of the major funders of hospice and palliative care internationally.
This session will explore the findings from the review of funding for hospice and palliative care around the world by the International Observatory on End of Life Care commissioned by the Open Society Institute. The aim of the study was to identify national and international foundations and agencies that provide funding for hospice and palliative care activities in developing countries.
In addition, the specific experience of the Open Society Institute's International Palliative Care Initiative as one of the major international funders of hospice and palliative care will be considered. The priorities of the Open Society Institute will be highlighted and the successes and challenges of international funding partnerships for hospice and palliative care will be explored.
Attendees will develop a greater understanding of the funding environment for hospice and palliative care internationally and learn more about the experience of international funding partnerships from the perspective of a key global funder.

PS 23.2

The Shepherd's Hospice and help the Hospices: Expanding health care in Sierra Leone with the UK government

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Opportunities for European hospice and palliative care organisations to access funding for projects with partners in the developing world continue to present themselves. These opportunities and funding sources are often unavailable to hospice and palliative care services around the world without the support of European partners.
The aim of this session will be to highlight the

potential for joint working across continents and how to access funds through worldwide partnerships, working towards the vision to achieve access to good quality care for all those who need it, wherever they are. The session will look at the process of identifying opportunities, successful application and implementation and the challenges and benefits in undertaking these projects. The focus will be on a project between hospice and palliative care organisations in the UK and Sierra Leone funded by the UK 's Department for International Development. Attendees will learn how partnerships between organisations in different continents can result in accessing funding that would otherwise have been unavailable for hospice and palliative care services working alone. The benefit to both partners will also be considered as well as the important contribution funding partnerships can have on the development of hospice and palliative care worldwide.

PS 23.3

Accessing funding from the Global Fund to fight AIDS, TB and Malaria for hospice and palliative care services

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The purpose of this session is to empower, inform and support attendees to access funding from the Global Fund to fight AIDS, Tuberculosis and Malaria.
Palliative care is a vital part of the care continuum for HIV and AIDS but unfortunately is often neglected by policy makers and funders. The AIDS pandemic has increased the need for palliative care and yet various barriers continue to hinder the development of hospice and palliative care in resource-constrained settings. One of the most prominent is lack of access to funding.
The Global Fund to fight AIDS, Tuberculosis and Malaria is one of the key international funders that tackles these three disease groups and many bilateral and multi-lateral agencies direct their funds through this funder to create harmonized and coordinated funding mechanisms and programmes. To date, the Global Fund has committed US$ 11.3 billion in 136 countries to support interventions against all three diseases. Unfortunately, despite the large sums of money available there is mixed reports of the experience of hospice and palliative care services on the ground in resource-constrained settings accessing the funds.
The session will highlight the experience of hospice and palliative care services worldwide in accessing 'Global Fund to fight AIDS, Tuberculosis and Malaria' funds and look at the key elements which have enabled funding to reach hospice and palliative care services. Practical advice and support will be given on engaging with Global Fund processes and maximizing the opportunities to access funding. In addition, the challenges and issues for hospice and palliative care services that have resulted from this funding stream will be considered.
Data has been gathered from an online survey, semi-structured interviews and a desk review of literature.
This project is funded by the Open Society Institute.

PS 24 Interventional pain therapy – A contradiction in Palliative Care?

PS 24.1

‚Difficult to treat' cancer pain

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By using the WHO pain ladder between 70 and 90% of all patients with cancer pain can be treated very easy and successful. The remaining patients are a task for palliative care physicians or special pain therapists. In some patients the cancer pain seems to be refractory to therapy. Due to the progress regarding oncological therapies, the life expectancy of cancer patients is growing, often complicated by complex pain syndromes and other burden symptoms.
The term 'difficult cancer pain' is not well defined. There could be three areas of 'difficult to treat' cancer pain identified:
1. complex chronic situations with an underlying pathophysiological cause (bone pain, visceral pain and neuropathic pain);
2. complex episodic pain with or without a pathophysiological cause (e.g. breakthrough pain) and
3. side effects or toxicity of opioids (e.g. psychiatric side effects, opioid induced pain, opioid incompatibility).
Modern cancer pain therapy and palliative care is able to treat the majority of difficult cancer pain syndromes successful. Beyond opioids the use of coanalgetic adjuvant medication and its differentiation is growing. The better understanding of the pathophysiology of pain and the mechanisms of opioid therapy results in more and more differentiated therapy options.
Despite the fact, that the progress in cancer pain therapy is remarkable, there remains a group of patients which need complex and interdisciplinary pain therapy. But also in this situation, the use of interventional pain therapy is absolutely seldom necessary and should be the last option.

PS 24.2

Continuous spinal analgesia: A no-go or a good option?

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What to do when systemic multiple drug treatment fails to provide sufficient pain control in palliative care? Such refractory pain (2 - 5 % of patients with cancer-related pain) not adequately managed by systemic medications is considered a good indication for continuous intrathecal (IT) analgesia. Patients with neuropathic or mixed pain often become refractory to systemic medications, or intolerant of adverse effects. IT analgesia, where drugs are delivered into the cerebrospinal fluid and act directly at the CNS, was shown to provide improved quality of life and pain relief, at lower doses and with fewer adverse effects. At present, morphine and hydromorphone are the most often used IT analgesics, sometimes combined with the co-analgesics clonidine or bupivacaine. However, the development of tolerance or opioid-induced hyperalgesia, the occurrence of severe adverse effects including suppression of the hypothalamic-pituitary axis and potential respiratory depression, often limit the IT use of opioids.
Recently, ziconotide (Prialt®), a novel non-opioid IT analgesic was licensed in US and in Europe for severe chronic pain including cancer-related pains. Ziconotide is a reversible N-type voltage-sensitive calcium channel blocker and so far is the only agent that has been specifically developed for IT use with pain as the primary indication. Efficacy and safety have been demonstrated by randomized, controlled and long-term open-label trials. The unique pharmacological properties of this biological drug lacking development of tolerance, physical dependence or respiratory depression led to a revision of the polyanalgesic concept and its current recommendation as a first line drug (together with morphine and hydromorphone) for IT analgesia.
In this presentation, the patients that may benefit from IT analgesia will be described, taking into account the diagnosis, life expectancy, the underlying physiology and the history of their pain including opioid refractoriness.

PS 24.3

Neurolytic procedures; why, when and how

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Although more limited than before,neurolytic blocks still have a certain role in the treatment of intractable cancer pain. Neurolysis is the prolonged destruction of axons or cell bodies of the somatic or sympathetic nerves by means of chemical agents such as alcohol and phenol or the application of thermocoagulation, cryo and laser.
These techniques should be applied only by physicians with experience as a part of a multi-modal therapy program in very carefully selected patients after detailed assessment. Selection criteria for neurolytic blocks are limited life expectancy,severe persistent pain not responding to conservative therapieslocalized somatic pain.
To apply nerve blocks; the pain must be well characterized, well localized, somatic or visceral in origin, not compromising a component of a pain syndrome of multifocal aches or pain. The selection of definitive neurolytic procedure is guided by the results of prognostic blocks done with local anesthetics.
The neurolytic blocks which may be used are;
Gasserian ganglion and branches
Phrenic nerve
Brachial plexus
Intercostal nerves
Intrathecal and epidural neurolysis
Pituitary alcohol injection
Neurolytic blocks of symphatetic axis; cervicothoracic (Stellate) ganglia
thoracic ganglia
splancnic nerves
celiac plexus
lumbar ganglia
hypogastric plexus
ganglion impar
All of these neurolytic blocks have certain complications and they should be performed always under imaging and with a close follow up. In this lecture where,how and why these neurolytic blocks should be used will be discussed.

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FC 01 Pain Therapy

FC 01.1

An international multicentre validation study of a pain classification system for advanced cancer patients

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Introduction: There is no universally accepted system to accurately predict the complexity of cancer pain management. The Edmonton Classification System for Cancer Pain (ECS-CP) was developed from the original Edmonton Staging System for Cancer Pain (ESS) (1989) and the revised ESS (rESS) (2005). An international multicentre trial to strengthen the generalizability of the ECS-CP as a standardized pain classification system in advanced cancer has been completed. The primary objective of the study was to assess predictive validity of the ECS-CP in a diverse international sample. We hypothesized that patients with less problematic pain syndromes would require a shorter time to achieve stable pain control, require less complicated analgesic regimens, be more responsive to opioid therapy and use lower opioid doses than patients with more complex pain syndromes.
Methods: A total of 1100 patients were recruited from 11 palliative care sites located in Canada, USA, Ireland, Israel, Australia and New Zealand (100 per site). A palliative care specialist completed the ECS-CP for each referred cancer patient. Additional information, including daily patient pain ratings, daily number of breakthrough pain doses, types of adjuvant pain treatments and opioid consumption was recorded until the study endpoint (i.e. stable pain control, discharge, death).
Results: 944/1100 pts had a pain syndrome (86%). Nociceptive 67%, Neuropathic 27%; Incident pain 49%; Psychological distress 44%; Addiction 11%; Cognition normal/impaired/unresponsive 69/21/8%. There were significant differences in the ECS-CP between sites. 51% achieved stable pain control. Analysis of predictive outcomes is pending.
Conclusion: An internationally recognized cancer pain classification system would enable clinicians to better manage cancer pain and allocate resources. The ECS-CP could play a significant future role in evaluating, treating and reporting research results in the assessment and management of cancer pain.

FC 01.2

Onset of action, consistency and acceptability of fentanyl pectin nasal spray (FPNS) with PecSys® in the treatment of breakthrough cancer pain (BTCP)

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Aim: To evaluate onset, consistency and acceptability of analgesia produced by a new nasal formulation of fentanyl (fentanyl pectin nasal spray [FPNS]) for treatment of breakthrough cancer pain (BTCP).
Background: The pharmacokinetics of FPNS indicate that it should have a relatively rapid onset of analgesia. Most BTCP episodes have a time course inconsistent with oral rescue medication; FPNS should provide more rapid onset of pain relief and potential for greater patient acceptability.
Methods: Patients (N=114) experiencing 1–4 BTCP episodes/day while taking ≥60 mg/day of oral morphine (or equivalent) for cancer pain were entered into a randomised, placebo-controlled, double-blind (DB) study (Archimedes CP043). Patients who found an effective FPNS dose during open-label titration continued to a DB phase (N=83) and treated 10 episodes of BTCP with either the effective dose (7) or placebo (3). Pain intensity (PI) was measured using an 11-point scale, pain relief using a 5-point scale; both measured at 5, 10, 15, 30, 45 and 60 min. Use of rescue medications was recorded. Subject acceptability assessments were made at 30 and 60 min post-dose.
Results: Only 6% (lack of efficacy) and 5% (adverse events) of patients failed to successfully titrate; 91% of randomised patients completed the study. A total of 659 BTCP episodes were analysed (FPNS N=459; placebo N=200). 33% of FPNS treated episodes showed onset of PI improvement at 5 min (P<0.05), 61% at 10 min and 73% at 15 min (both P<0.0001) vs placebo. By 30 min, 60% of episodes had clinically relevant pain relief (≥33% fall in PI; P<0.0001 vs placebo). Only 9.4% of episodes required rescue medication. Patients were "satisfied" or "very satisfied" with the convenience (70%) and ease of use (68%) of FPNS; 87% of patients elected to continue treatment post-study.
Conclusion: FPNS provided a relatively rapid onset of analgesia in BTCP and was well accepted by patients.
Sponsored by Archimedes Development Ltd.

FC 01.3

Comparison of intranasal fentanyl spray (INFS) with oral transmucosal fentanyl citrate (OTFC) for the treatment of breakthrough pain in cancer patients: An open-label randomised, balanced crossover trial

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Aim: Breakthrough pain (BTP) is often intense, has a characteristically fast onset and short duration, with most episodes resolving within 60 min, or less. Oral morphine, often used to treat BTP, has onset of action of ≥30 min and duration of effect of 3-4 hours. In addition, oral transmucosal fentanyl citrate (OTFC) is currently indicated to treat BTP. The intranasal fentanyl spray (INFS) is a non-invasive formulation designed to provide fast onset of action and short duration of effect that matches the BTP episode. The trial reported was designed to compare directly the efficacy of INFS with that of OTFC for relief of BTP among in-/outpatients with cancer.
Methods: This was a multi-national, multi-centre crossover trial involving 115 patients receiving chronic opioid treatment equivalent to 60-500 mg oral morphine/day or to 25-200µg/hour transdermal fentanyl and experiencing ≥3 BTP episodes/week and £4 /day. The efficacy of INFS titrated to an effective dose of 50, 100, or 200 µg fentanyl was compared with that of OTFC titrated to an effective dose of 200, 400, 600, 800, 1200, or 1600 µg fentanyl, to treat six BTP episodes. The primary efficacy measurement was time to onset of meaningful pain relief, as judged by the individual patient, recorded by stopwatch. Pain intensity difference scores (PID) at 10 and 30 min (PID10, PID30) for the two agents, sum of PIDs between 0 and 15, 0 and 60 min (SPID0-15, SPID0-60), general impression (GI) score after 60 min, ease of administration and treatment preference, and AEs were also recorded.
Results: The study is complete and data are being analysed. Data will be presented comparing the time to onset of meaningful pain relief provided by INFS vs. OTFC, in terms of the proportion of patients experiencing a faster onset of meaningful pain relief for each drug.
Conclusions: This trial was the first to investigate the exact time of the onset of meaningful pain relief with INFS and OFTC and measure any difference between the two.

FC 01.4

Fentanyl pectin nasal spray (FPNS) with PecSys® (100, 200, 400, 800 µg): Pharmacokinetics and relative bioavailability compared with oral transmucosal fentanyl citrate (OTFC; 200 µg)

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Aims: To compare the pharmacokinetic profiles of fentanyl pectin nasal spray (FPNS) 100, 200, 400, and 800 µg doses and assess relative bioavailability with oral transmucosal fentanyl citrate (OTFC) 200 µg.
Background: Compared with conventional oral delivery, the nasal route offers the potential to enhance fentanyl delivery and better match the time course of breakthrough cancer pain (BTCP) where a rapid and predictable onset of action is required. FPNS is a new nasal formulation that forms a gel on the nasal mucosa to optimise fentanyl absorption in a controlled manner.
Methods: This Phase I, single-dose study (Archimedes CP042) was conducted in 17 healthy adult volunteers treated with naltrexone hydrochloride to block centrally mediated opioid effects. Subjects were dosed on 5 occasions, separated by a ≥3-day washout period, with 4 FPNS doses (100, 200, 400, and 800 µg) and OTFC (200 µg). A multidose nasal drug delivery system, using 2 FPNS strengths (100 µg/100 µL and 400 µg/100 µL), was used to deliver 1-2 sprays to achieve desired dose. Fentanyl venous plasma concentrations were measured before and up to 48 hours post-dose. Dose proportionality, safety and tolerability of FPNS were examined across the dose range.
Results: Median Tmax values for FPNS were 15 to 20 min post-dose (vs 90 min for OTFC) and were dose independent. Cmax values were 2.3-fold higher for FPNS 200 µg compared with OTFC 200 µg. The dose-normalised mean relative bioavailability of FPNS to OTFC for each dose ranged between 111% and 180% for AUC∞ and AUCt. Dose proportionality for FPNS Cmax across the range was confirmed. Drug absorption based on AUC∞ also appeared to increase in a dose-proportional manner.
Conclusions: Across the dose range, Cmax and AUC increased in a dose-proportional manner. The FPNS pharmacokinetic profile appears to better match the characteristic patterns of BTCP compared with OTFC. FPNS was generally well tolerated.
Sponsored by Archimedes Development Ltd.

FC 01.5

Tolerability and safety of intranasal fentanyl spray (INFS) for treatment of breakthrough pain in patients with cancer: results of a 10-month open-label extension study

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Aim: To establish long-term tolerability and safety of treatment with intranasal fentanyl spray (INFS) doses of 50, 100, and 200 µg for breakthrough pain (BTP) in patients with cancer.
Methods: This was a randomised, double-blind, placebo-controlled, crossover trial with 120 adult in-/outpatients receiving stable, chronic opioid therapy and experiencing ≥3 BTP episodes per week and £4 per day. Patients were titrated to INFS doses of 50, 100, or 200 µg, which were then used to treat (in a randomised, double blinded sequence) 6 of 8 BTP episodes (£4 per day), and placebo for 1 BTP episode each of episodes 1-4 and 5-8, respectively. Patients then entered an open-label treatment phase and given bottles delivering their effective dose of INFS sufficient for approximately one month of use. Tolerability was monitored for 10 months after inclusion of the last patient in the trial.
Results: Of 120 enrolled patients, 111 (ITT) entered and 110 completed the efficacy phase, and 108 entered the extension study. Mean pain intensity difference at 10 minutes (PID10) after dosing with INFS was twice as high (2.36) as placebo (1.10, P < 0.0001). In all 99 patients (82.5%) experienced AEs: 38 (31.9%) in the titration, 22 (19.8%) in the efficacy, and 83 (76.9%) in extension open label phase. A total of 16 patients had AEs probably /possibly related to INFS treatment: 7 (5.9%), 6 (5.4%), and 5 (4.6%), respectively, during the

three trial phases. Unrelated malignant neoplasm progression was the most frequent severe AE (41 patients; 38.0%), SAE (44 patients; 40.7%), and the most frequent reason for withdrawal (44 patients; 40.7%). During the extension study, 47 patients (43.5%) discontinued due to AEs. Altogether, 15 patients completed the 10-month extension study.
Conclusions: INFS at doses of 50-200 µg was effective in relieving BTP and shown to be safe and well tolerated both locally and systemically during an extended open-label treatment period.
Source of funding: This study was sponsored by Nycomed, Denmark.

FC 01.6

Are pain and depression interdependent in cancer: A longitudinal study

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Aims: Pain and depression are highly prevalent symptoms in cancer patients. Epidemiological studies have shown that pain and depression often co-exist and thus the relationship between these symptoms is of interest. Studies have shown a statistically significant association between pain and depression and it has been suggested that these symptoms may be inter-dependent. Although associations exist, there are no published studies that examine the relationship between these symptoms. The aim of this study is to examine the relationship between cancer pain and depression.
Methods: 60 patients with advanced cancer and cancer induced bone pain were assessed as part of this study. All patients had assessments of mood (Hospital Anxiety and Depression Scale) and pain (Brief Pain Inventory) at study baseline. Patients then received a therapeutic intervention (radiotherapy + optimisation of analgesia). Further assessments of mood and pain were undertaken four weeks from study baseline. No patients had commenced antidepressant medication (in the four weeks prior to study entry) or had started antidepressants during the study period.
Results: Full statistical analysis of study results is awaited. Preliminary results show an improvement in pain following the therapeutic intervention. The median total BPI score pre- and post- intervention was 49 (range 32-88) and 13 (range 0-52) respectively. The median total HADS score pre- and post- intervention was 13 (range 2-22) and 9 (range 1-18) respectively. In patients who had a 30% or more reduction in their BPI score (total score) there was a statistically significant reduction in HADS score ($p<0.05$).
Conclusions: This is the first study that examines the natural evolution of anxiety and depression in patients with pain who have pain treated actively, whilst no anti- depressive intervention is administered. Results support the theory that the active treatment of cancer pain results in an improvement in anxiety and depression.

FC 02 Dyspnoea and insomnia

FC 02.1

Does palliative home oxygen improve dyspnoea? A consecutive cohort study

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Introduction: Palliative oxygen for refractory dyspnoea is frequently prescribed, even when the criteria for long-term home oxygen (based on survival, rather than the symptomatic relief of breathlessness) are not met. Little is known about how palliative home oxygen affects symptomatic breathlessness.
Methods: A four year consecutive cohort from a regional community palliative care service in Western Australia was used to compare baseline breathlessness before oxygen therapy with dyspnoea sub-scales on the symptom assessment scores (SAS; 0-10) one and two weeks after the introduction of oxygen. Demographic and clinical characteristics of people who responded were included in a multivariable logistic regression model.
Results: Of the study population (n=5,862), 21.1% (n=1,239) were prescribed oxygen of whom 413 had before and after data that could be included in this analysis. The mean breathlessness before home oxygen was 5.3 (SD 2.5; median 5; range 0-10). There were no significant differences overall at one or two weeks ($p=0.28$) nor for any diagnostic sub-groups. One hundred and fifty people (of 413) had more than a 20% improvement in mean dyspnoea scores. In multi-factor analysis, neither the underlying diagnosis causing breathlessness nor demographic factors predicted responders at one week.
Discussion: Oxygen prescribed on the basis of breathlessness alone across a large population predominantly with cancer does not improve breathlessness for the majority of people. Prospective randomised trials in people with cancer and non-cancer are needed in order to determine whether oxygen can reduce the progression of breathlessness compared to a control arm.

FC 02.2

Palliative oxygen versus medical air for relief of dyspnea: Results of an international, multi-site, randomized controlled trial

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Background: Although the survival benefit of oxygen therapy for severely hypoxemic COPD patients ($PaO2 \leq 55$ mmHg) is well-established, its symptomatic effectiveness for patients with intractable dyspnea at life's end is unclear.
Aim: To compare oxygen with medical air for relief of palliative refractory dyspnoea.
Methods: This double-blind RCT recruited from 9 sites in Australia, the USA, and Britain. Participants received blinded oxygen or medical air at 2 litres/minute, >15 hours/day for 7 days. Primary outcome was breathlessness on a 0-10 numerical rating scale (NRS) measured twice daily; quality of life (QOL; McGill QOL Questionnaire) was secondary. Longitudinal repeated measures mixed models with unstructured covariance matrices were used to assess effects of time, intervention, and their interaction. Responders were individuals with >1 point NRS improvement; predictors of response were explored.
Results: Participants (n=239) were: mean age, 73 (SD 10); 62% male; 64% COPD; mean PaO2, 77 (SD 12). Neither gas proved superior in relieving the sensation of dyspnea ($p=0.456$) or improving QOL ($p=0.281$). Dyspnea and QOL improved over the study period in both arms ($p<0.0001$ for each outcome). Significant predictors of morning response were: oxygen use (OR 1.86, $p=0.0344$), and high baseline breathlessness (OR 0.20, $p=0.0003$). Blinded responders were more likely to want to continue treatment than non-responders (51% vs 39%; $p=0.0753$); 56% of those with NRS response reported symptomatic improvement.
Conclusions: Overall, palliative oxygen conferred no additional benefit over medical air for relieving dyspnea or improving QOL in this study population. People with more severe breathlessness may derive more benefit from palliative oxygen.
Implications for practice: Use of palliative oxygen for the symptomatic management of dyspnea in mildly hypoxemic people is not supported by this adequately-powered RCT. Selected patients benefit from the intervention.

FC 02.3

Effect of nebulised fentanyl in patients with refractory dyspnea

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Aims: Dyspnea is one of the most frequent and distressing symptoms experienced by terminally ill cancer patients. The palliation of the dyspnea significantly improves patient comfort as the progression of the disease worsens. The aim of effective dyspnea management is to minimize the patient´s perception of breathlessness. For this purpose, we evaluated the role of nebulised fentanyl citrate as an adjuvant for the palliation of dyspnea in end-of-life care cancer patients.
Methods: 20 end-of-life care cancer inpatients with dyspnea refractory to systemic opioids inhaled one dose of fentanyl citrate 100 mcg. Dyspnea was assessed at baseline and 15 minutes after fentanyl administration using visual analogue scale of dyspnea (VAS) reported by patient and caregivers. Changes in respiratory rate (RR) were also noted. Statistical analysis was performed with SigmaStat software. The Kolmogorov-Smirnov test was applied to test normality of the data and differences among the groups were assessed by Kruskal-Wallis One-Way ANOVA followed by Dunn's Test. A p value < 0.05 was considered significant.
Results: 19 (95%) patients reported improvement in the subjective feeling of less air hunger after treatment. Dyspnea was improved as measured by a decrease in VAS of more than 20% in 17 (85%) patients. Total VAS scores and RR were significantly decreased after fentanyl inhalation ($p < 0.001$ compared to baseline). In 16 (80%) patients, a slight sedation and low levels of anxiety were perceived after fentanyl treatment. No major adverse reactions were detected.
Conclusion: Our preliminary data disclosed that nebulised fentanyl improved patients´ perception of breathing. This low-cost and accessible treatment may offer considerable relief of dyspnea and its use may be advantageous in terminally ill patients with refractory dyspnea.

FC 02.4

Multi-site open label dose ranging study to determine the minimum effective dose of sustained release morphine (SRM) for reducing refractory dyspnoea ACTRN012606000269538

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Introduction: Previous randomised placebo-controlled trials have identified that SRM offers clinically significant symptomatic benefit for refractory dyspnoea. At the time of the study the lowest dose available was 20mg / 24 hours. The aim of this study is to define the lowest effective dose of SRM for reducing dyspnoea (Stage I) and report on its long term net clinical benefits (Stage II).
Methods: An open labelled dose ranging study was performed in three teaching hospitals across Australia. Stage I people received 10mg of SRM each morning for one week. If there was clinical benefit (>10% reduction in dyspnoea on average over the last three days of the week), 10mg SRM was prescribed long-term (Stage II). If no clinical benefit, and no unacceptable side effects, dose was increased to 20mg daily and the algorithm repeated. The maximum dose used was 30mg / 24 hrs. Unacceptable side effects lead to study withdrawal. People on Stage II were followed until death or cessation of morphine.
Results: To date, a total of 48 participants have completed stage I. Of these, 19 derived clinical benefit at 10mg/24 hrs, 5 at 20mg/24 hrs, and 3 at 30mg/24 hrs. Four participants withdrew at 10mg /24 hrs because of unacceptable side effects, 6 at 20mg/24 hrs, and 3 at 30 mg/24hrs. Other than morphine side effects, 5 had no benefit on 30mg, 1 patient died, 1 participant withdrew. For stage II, a total of more than nine patient/years of data have been collected. In this phase, further dose escalations have not been seen, and once established on dose, people have not withdrawn because of lack of effect or side effects. Overall, 27 of 48 people (56 %) had a net clinical benefit sufficient to continue opioids for their refractory dyspnoea.
Discussion: This study suggests that even low doses of SRM provide long term benefit and it is reasonable to start with doses as low as 10mg daily, titrating up to 30mg daily slowly if there is lack of response and tolerable side effects.

FC 02.5

Course of breathlessness over time in patients with advanced cancer and COPD

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Aim: Breathlessness is a common and distressing symptom in patients with advanced disease. Most information comes from cross-sectional studies but little is known about breathlessness trajectories over time. The aim of this study is to describe and compare the course of breathlessness over time in patients with advanced cancer and severe COPD.
Methods: Longitudinal study in breathless patients with advanced cancer or COPD stage III/IV. Monthly data collection with postal questionnaires (including modified Borg scale). Trajectories of patients who provided Borg scores ≥ 3 time points were analysed using visual graphical analysis (VGA) and grouped. For reliability, a second researcher regrouped the trajectories.
Results: Between June 2006 and May 2007 49 cancer and 60 COPD patients were recruited and followed up for six months or until death. 30/49 cancer and 6/60 COPD patients died during data collection. 21/49 cancer patients and 43/60 COPD patients provided data for individual breathlessness trajectories. After visual analysis, four different trajectory groups could be identified in both disease groups (% cancer/ COPD): stable (33/19), fluctuating (33/47), increasing (14/26) and decreasing (19/2) breathlessness. Inter-rater agreement was high for both conditions (Cohen's kappa 0.93 for the cancer and 0.85 for the COPD group).
Discussion: Breathlessness follows different trajectories. Fluctuation and increase of breathlessness are the most common trajectories in COPD patients whereas fluctuation and stable trajectories seem to be most common in cancer patients. However, numbers of cancer patients are small as many patients died during data collection and thus data from this group is very limited and has to be interpreted with caution. Longitudinal studies in palliative care populations are still challenging but give important insights. VGA is a reliable and useful form to analyse longitudinal data of relatively small sample size.

FC 02.6

Insomnia and related factors in a palliative care unit

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Aims: To determine the prevalence of insomnia in a Palliative Care Unit (PCU) and related factors.
Methods: 138 patients consecutively admitted in PCU were submitted to the following inclusion criteria: >3 days hospitalization, Pfeiffer Questionnaire punctuation ≤4 and Karnofsky Index ≥30. Forty-five patients (32%) met these criteria. Insomnia was detected through the question "Have you been suffering from insomnia since you have been admitted?" and evaluated by the Sleep Disturbance Scale (SDS) (range 0-10). Physical, psychological and environmental factors that might be related to insomnia were registered. Emotional distress was also measured by the Hospital Anxiety and Depression Scale (HADS). The origin of patients (acute care vs home), pharmacological treatment and the nature and extension of disease were collected.
Results: Among the 45 patients included, 53.3% were men, 63.6% came from acute care, 93.3% suffered from cancer, 59.5% with disseminated cancer, and the mean age was 72.2±11.0. The prevalence of clinically significant emotional distress (HADS≥19) was 62.2%. The question regarding insomnia was answered affirmatively by 51.1% of patients. It was significantly associated with coming from acute care (p=0.03), presence of dyspnea (p<0.01), diurnal somnolence (p<0.01) and feeling of non-restorative sleep (p<0.05). Moderate to severe insomnia (SDS≥5) was present in 35.5% of patients, and was only associated with disseminated cancer (p=0.04).
Conclusions: Insomnia was a frequent symptom in PCU, more frequently reported by patients coming from acute care, those presenting dyspnea, diurnal somnolence and feeling of non-restorative sleep. Moderate to severe insomnia was associated with disseminated cancer. Patients in PCU presented a high level of emotional distress. Insomnia in PCU seems to be dependent on cancer status; organic changes or treatment associated with advanced disease may contribute to sleep cycle disruption.

FC 03 Gastrointestinal Symptoms and Cachexia

FC 03.1

EPCRC clinical guidelines on cancer cachexia: Draft recommendations

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Aims: The European Palliative Care Research Collaboration (EPCRC) is developing evidence based clinical practice guidelines for pain, depression and cachexia in advanced cancer patients.
Methods: Key questions represented the scope of the guidelines. Scoping literature reviews led to draft recommendations for these key questions which were presented to an external expert pool in a consensus procedure. Systematic reviews and consensus methods will be used to develop the final version of the guidelines.
Results: Key questions have been formulated and discussed at the EAPC-Congress in June 2007, as well as with experts and stakeholders on the web. A broad spectrum of fields and topics has been included such as definition, epidemiology, aetiology, pathophysiology, assessment and classification, psycho-social and ethical issues, as well as drug and non-drug treatment. Following this discussion 17 draft recommendations in 5 categories have been formulated. In respect of the palliative care setting the draft recommendations are addressing the net-benefit of the intervention for the patient, not only the efficacy itself.
The draft recommendations include enteral nutritional therapy (probably do it) for nutritional treatment; megesterol progesterin (probably do it), steroids (do it) and prokinetics (probably do it) for drug treatment; nutritional counselling and education (do it), psychotherapeutic interventions (do it), physical training or other physical treatment options (do it) for non-drug treatment; multimodal therapy (probably do it), prophylaxis (probably do it).
To uncover discordance experts have been asked for their ratings on these draft recommendations using the Delphi consensus method. Where no or little consensus is reached the evidence will be evaluated by systematic reviews.
Conclusions: Draft recommendations take a central position for the evaluation of consensus and evidence in the guideline developing process.

FC 03.2

EPCRC guidelines on cancer cachexia: First results form a Delphi procedure

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Aims: The EPCRC will develop clinical practice guidelines for the treatment of pain, depression and cancer cachexia in advanced cancer patients. To uncover fields of discordance between experts in the guideline developing process we performed a Delphi consensus procedure on draft recommendations.
Methods: From a list of clinical key questions draft recommendations were constructed using the GRADE system. A Delphi process with two rounds has been performed to reach consensus on these draft recommendations. Experts (clinical cachexia experts, palliative care professionals and other stakeholders) have been identified and were asked to participate in this consensus procedure. A 0 to 10 scale has been used covering the range from total disagreement to total agreement. A mean score ≥7 indicates agreement, a mean score £3 indicates disagreement. The answers of the first round have been processed and circulated back to the participants asking for revision of their answer.
Results: Answers from 26 experts from different positions were evaluated after the first round. Mean consensus score ranged from 6.52 to 8.52 in the 17 statements. Mean scores were above 7 for 13 statement, indicating adequate consensus. For the 17 statements between 0 and 19% of respondents scored £3, and 54 to 92% scored ≥7.
Highest mean scores were reached for recommendations on nutritional counselling (do it), prokinetics (probably do it) and steroids (do it).
Conclusions: Using scoping literature reviews and the GRADE methodology it was possible to produce draft recommendations that met high consensus with clinical experts. Completition of the Delphi procedure will lead to the final set of recommendations for the clinical practice guideline.

FC 03.3

Weight-loss alone is insufficient to define and classify cancer cachexia in advanced pancreatic cancer

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Aim: Cancer cachexia is a major contributor to morbidity in advanced pancreatic cancer (PC). However, few evidence based strategies for treatment of this condition and for symptom alleviation exist. A major obstacle may be the lack of an agreed-upon definition. This prospective study classified PC patients according to two suggested definitions. The purpose was to evaluate their ability to discriminate between patients in terms of morbidity and well being.
Methods: A total of 39 Norwegian patients with advanced PC, 18 females (46%), 21 males were included from 2006 to 2008. EORTC QLQ-C30 and ESAS were used to assess quality of life and symptoms at diagnosis. Two definitions of cachexia were used for classification: (A) The conventional definition based on > 10% weight loss, and (B) A definition based on three key factors, weight loss > 10%, reduced food intake (<1500 kcal/d), systemic inflammation (CRP >10mg/l), defined as cachexia when ≥ 2 of 3 factors were met.
Results: Median age was 62 years, median ECOG status one. Seventeen patients (44%) had locally unresectable cancer, 16 (41%) metastatic and six (15%) recurrent disease. Weight loss > 10% identified 28 (72%) patients as cachectic. They reported significantly more fatigue than the others (mean scores 39 vs 58; p<0.05) on the QLQ-C30. When classified with ≥ 2 of 3 factors, 26 patients (67%) were cachectic. These patients reported significantly more fatigue (37 vs 61, p < 0.01), pain (21 vs 53, p < 0.01) and poorer global health (65 vs 48; p<0.05), physical (78 vs 62; p<0.05) and emotional functioning (80 vs 74; p< 0.05) than non-cachectic patients. Mean ESAS scores were significantly higher for pain, fatigue and xerostomia.
Conclusion: A 3-factor cachexia model provides more information about symptoms that may reflect nutritional deterioration in advanced PC, than weight loss alone. A potential interaction between nutritional deterioration and morbidity should be evaluated in larger patient samples.

FC 03.4

Randomised phase III clinical trial to evaluate the efficacy and safety of an integrated treatment (diet, pharmaco-nutrional and pharmacological) in cancer patients with cancer-related anorexia/cachexia and oxidative stress: Interim results

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Aim of the study: In April 2005 we started a phase III randomised study to establish the most effective and safest treatment of cancer cachexia (CACS) addressing

as primary endpoints: lean body mass (LBM), resting energy expenditure (REE), total daily physical activity, serum IL-6, TNF-α and fatigue.
Methods: The sample size was 475 patients (pts). Eligibility criteria: hystologically confirmed tumors of any site; weight loss ≥ 5% in the last 3 months and/or abnormal values of laboratory parameters predictive of the onset of CACS; life expectancy > 4 months. All pts enrolled received as basic oral treatment: poliphenols + alpha lipoic acid + carbocysteine + Vitamins ACE. Pts were then randomised to one of the following 5 arms:
1) Medroxyprogesterone Acetate (MPA)/ Megestrol Acetate (MA);
2) Pharmaco-nutritional support containing EPA;
3) L-carnitine;
4) Thalidomide;
5) MPA/MA + Pharmaco-nutritional support + L-carnitine + Thalidomide.
Treatment duration was 4 months. Interim analyses were planned after every 100 randomized pts.
Results: At September 2008, 280 pts were randomized and 240 were evaluable: M/F 167/113, mean age 62 yrs (range 30-84), 95% stage IV. A first interim analysis on 125 pts showed a significant worsening of LBM, REE and fatigue in arm 2 in comparison to the others and it was withdrawn from the study. A second interim analysis after the enrolment of 204 pts showed arm 1 significantly less effective than the others for primary efficacy endpoints: it was withdrawn from the study. Statistical analysis at September 2008 showed a significant improvement of LBM (by DEXA), REE and fatigue in arm 5 and a significant decrease of IL-6 in arm 3 and 5 and TNF-α in arms 3 and 4. As for safety, the treatment was overall well tolerated and the patient compliance was good.
Conclusion: The results so far seem to suggest that the most effective treatment for cancer pts with CACS should be a combination regimen.

FC 03.5

A post-hoc analysis of gastrointestinal adverse events with methylnaltrexone treatment in patients with advanced illness and opioid-induced constipation

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Aim: Methylnaltrexone, a selective μ-opioid receptor antagonist, decreases peripheral effects of opioids without affecting centrally-mediated analgesia. The efficacy and safety of subcutaneous methylnaltrexone in patients with advanced illness and opioid-induced constipation was demonstrated in 2 phase 3 studies. Methylnaltrexone significantly induced laxation within 4 hours of dose (62% and 58% for methylnaltrexone 0.15 [N=47] and 0.3 mg/kg [N=55], respectively vs 14% for placebo [N=52] in study 1 [single dose]; 48% for methylnaltrexone 0.15 mg/kg [N=63] vs 16% for placebo [N=71] in study 2 [multiple dose]). Abdominal pain (preferred term) was the most frequently reported adverse event (AE). This post hoc analysis further examined abdominal pain AE seen in the double-blind (DB) and open-label (OL) portions of the 2 phase 3 studies.
Methods: In these studies, AE verbatim terms from individual case report forms were coded to preferred terms using the Medical Dictionary for Drug Regulatory Affairs ver. 6.0. Descriptive summary statistics were reported for the post-hoc analysis.
Results: During the treatment period in the 2 DB studies, 47 (29%) patients receiving methylnaltrexone (vs 12 [10%] placebo) reported abdominal pain as an AE, which was mostly mild to moderate in severity. In verbatim terms, abdominal pain was most often reported as "abdominal cramping" or "cramps" (>80% of patients with abdominal pain). Across all phases of the 2 studies, the highest incidence of abdominal pain was reported for methylnaltrexone dose 1 and decreased for dose 2 (study 1: 31% after dose 1, 20% after dose 2; study 2: 13% after dose 1, 3% after dose 2). The decreasing trend was maintained for subsequent doses.
Conclusions: Abdominal pain was reported predominantly for the first dose of methylnaltrexone and was most often described as abdominal cramping/cramps in verbatim terms. After the first dose, the incidence of abdominal pain substantially decreased with subsequent doses.

FC 03.6

Oral symptoms in palliative care and their association with local microbiological and clinical findings

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Introduction: Oral symptoms like dry mouth, difficult swallowing, local pain, halithosis or disturbances of taste play a relevant part for patients in palliative care. Underlying causes have been described in oncological settings with regard to cancer therapy associated toxicity. In palliative care though, the underlying causes for oral symptoms and their correlation to the clinical course, drug intake, local findings and local microbiological features, have not been sufficiently investigated.
Method: One hundred consecutive patients (89 pts. preliminary) of our palliative care unit have been evaluated with regard to their clinical course (incl. drug intake and time passed since last cancer therapy), subjective symptom burden (Midos) and oral symptoms. The oral status was examined and documented by a dentist, followed by swab and mouth wash for semi-quantitative bacteriological and mycological culture and for herpes simplex virus PCR.
Results: Dry mouth and taste disturbances were the most often reported oral symptoms, associated to any of the given clinical or microbiological findings. In almost all (86/89) patients, coating (17/86 candida-like plaques) were found as the most prevalent clinical finding. Candida-like plaques, positive candida cultures or HSV PCR, anticholinergic drugs, benzodiazepines or opioids were also strongly associated with the perception of dry mouth, less often with perception of altered taste. A dental co-factor to symptom development was not identified. In 4 patients, multiresistant bacteria colonisation was diagnosed incidentally.
Discussion: In summary, we could not give proof of a clear cut correlation between a single item symptom and a single clinical finding; the most prevalent symptoms and the most prevalent clinical signs were reported or found independently. This challenges a day to day practice where diagnostic routine instead of a symptom-guided approach dominates treatment decisions for palliative mouth care.

FC 04 Assessment and Measurement Tools

FC 04.1

Assessing the level of unmet palliative needs in a nationally representative sample of Danish advanced cancer patients

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Aims: Little is known about the need for palliative care among advanced cancer patients who are not in specialist palliative care. The aim of this study was to assess the need for palliative care in a nationally representative sample of advanced cancer patients.
Methods: All hospital departments from three regions in Denmark were invited to participate. From each department a list of patients with cancer was retrieved from the patient register. The medical records of the patients were reviewed and patients were included if they had cancer stages 3 or 4. Participating patients filled in the newly developed and validated 3-levels-of-needs-questionnaire (3LNQ). An unmet need was defined as a) having received 'insufficient help', or b) having received 'no help despite a wish for help'. Twelve areas of needs were assessed.
Results: In total, 54 (68%) of the hospital departments participated. A questionnaire was sent to 1,630 patients and 977 (60%) participated. The most frequent unmet needs were related to fatigue (35%), limitations in physical activities (32%), limitations in work and daily activities (32%), worries (31%) and sexual life (28%). For each need, about half of the patients who reported that they had received help, had received 'insufficient help'. Among those who reported that they had received no help, about two thirds had a wish for help.
Conclusion: This is probably the first study that measures needs in a representative sample of advanced cancer patients, and the first study differentiating between 'insufficient help' and 'no help despite a wish for help'. It shows that advanced cancer patients in Denmark have unmet needs, and that a large proportion of patients receives 'insufficient help' or 'no help, despite a wish for help'. Improvements in palliative care are warranted.
Acknowledgement: The study was supported by the Danish Cancer Society (PP01006 and PP05033), and the Ministry of Health´s Grant for Development and Analysis (2003-0201-39).

FC 04.2

Evaluation and comparison of two prognostic scores and the physicians´ estimate of survival in terminally ill patients

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Background: Most terminally ill patients request information about their remaining life span. Professionals are not generally willing to provide prognosis on survival, even though they are expected to be able to do so from their clinical experience. This study aims to find out whether the Palliative Prognostic Index (PPI) and the Palliative Prognostic Score (PaP-S) are appropriate, specific and sensitive to estimate survival time in patients receiving inpatient palliative care in Germany.
Method: PPI and PaP-S were assessed in addition to the core documentation data set of the Hospice and Palliative Care Evaluation (HOPE) for patients admitted to the palliative care units in Aachen, Bonn and Cologne. Time of survival was defined as the difference between the day of completion of the instruments (excluded) and the day of death (included).
Results: Survival time was compared with physicians´ estimations and prognostic scores in 83 patients. Whereas the estimates of the PPI and the PaP-S correlate highly, even higher correlations are found for the physicians´ prognosis and the scores. Correlations between survival time and the prognostic scores or physicians´ prognosis were lower. Physicians overestimated survival time on average fourfold.
Discussion: The prognostic scores are not able to produce a precise, reliable prognosis for the individual patient. Nevertheless they can be used for ethical decision making and for team discussions.
The physicians´ clinical estimation is more often in line with patients´ survival time and test results for very bad or very good prognosis than with moderate.

FC 04.3

How is depression assessed and classified in studies from palliative cancer care?

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Background: Depression is one of the most studied mental disorders in palliative care. Still there exist no agreed-upon methods on how to assess and classify depression either for research or clinical purposes.
Methods: A systematic literature review was performed within the framework of The European Palliative Care Research Collaborative (EPCRC). Extensive electronic database searches as well as hand search were carried out. Studies assessing and/or classifying depression in a palliative cancer care setting were included. .

Results: Although heterogeneity in assessments was expected, the diversity in the reviewed papers was more pronounced than anticipated. In the 202 included papers, 106 different assessment methods were used. Sixty-five of these were only used once. There were in total few case-definitions of depression. The classifications were in general based on cut-off scores (77%) and not according to diagnostic systems. Among these, the full range of the DSM-IV diagnostic criteria was seldom assessed, i.e. less than one third of the assessments in the review took into account the duration of symptoms and 18% assessed consequences and impact upon patient functioning. Thus, it is not possible to distinguish formal depression from normal and transient reactions.
Conclusions: A diversity of assessment methods has been used. Few studies classified depression by referring to a diagnostic system or by using cut-off scores. This has negative consequences for the estimation of prognosis and evaluation of treatment. Evidently, there is a need for a consensus on how to assess and conceptualise depression and related conditions in palliative care.

FC 04.4

Personal dignity at the end-of-life: Comparing the patient dignity inventory with open-ended questions

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Background: Chochinov has developed the Patient Dignity Inventory (PDI) for measuring factors important to maintaining or hampering dignity based on studies among terminally ill cancer patients in Canada. It is not known to what extent the items are valid for use in other patient groups and in other countries.
Aims: To compare answers to an open-ended question on factors important to dignity with answers on the PDI among Dutch people with an advance directive (people with different health status).
Methods: Quantitative framework of this study is the cohort of people with an advance directive. In the second measurement round (n=5477, spring of 2007) the cohort was randomly split in half. For one half the PDI (version of 2006) was included in the written questionnaire, while the other half received an open question on factors important to dignity. The open-ended question were coded. The coding scheme was compared to the PDI to assess to what extent all important items revealed with the open-ended question were represented in the instrument.
Results: The respondents that filled in the PDI considered most items of the instrument of influence to personal dignity. Items that were least often considered of influence were 'changes in physical appearance' (18% with score 4 or 5 on scale from 1 to 5), and 'not feeling you made a meaningful or lasting contribution' (23). The items of the PDI provided a solid base for the coding scheme for the open-ended question. All items were mentioned, sometimes in more detail: being treated with respect could be divided among others in respect for religion, respecting patient wishes, being taken serious by the physician. Influential factors that were not reflected in the PDI were care characteristics (e.g. cared for in a quiet or safe place), and being able to communicate.
Conclusions: Although more qualitative methods provide more detailed information, the PDI seems suitable for use among Dutch people with an advance directive.

FC 04.5

Medical errors and patient safety in palliative care

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Aims: Patient safety has become a relevant concern as studies have shown that errors in medicine are frequent and carry huge financial and moral costs. This has led to research efforts concerning the causes and prevention of medical errors, especially in surgery and intensive care. As a result, organizational interventions were designed that proved to reduce medical errors and improve patient care. For palliative care as a novel discipline with distinguishing features, it has not been established yet, what medical errors mean, how they are detected, prevented and dealt with. Our aim was to review the research on medical errors in palliative care and formulate a research agenda.
Methods: We performed a systematic literature review using the database PubMed. For the last ten years, we screened for the keywords "palliative care"/"palliative medicine"/"end-of-life care"/"terminal care" and "medical error"/"patient safety". The identified publications were classified according to type, content and quality, and empiric research results were extracted and critically assessed.
Results: The few studies we identified on medical errors in palliative care were mostly case studies and editorials. There are some empiric studies on errors in prognostication, advance care planning, communication and analgesia. The methodological approaches of these studies are diverse and often inadequate. The definition of error in palliative care has not been addressed and there is no study describing what patients, relatives or health care professionals think about errors in palliative care.
Conclusion: There is a need for both theoretical and empirical research on errors in palliative care. Three questions should be addressed first:
(1) How is an error in palliative care defined and what kinds of errors are there?
(2) How can errors in palliative care be detected and prevented efficiently?
(3) How should professionals communicate with their patients about committed errors?

FC 04.6

Clinical operations in a comprehensive integrated palliative medicine program

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Aims:
1) describe the clinical operations of a comprehensive integrated program that ensures efficient delivery of services in acute care
2) enumerate the advantages of the program for clinical, financial and research objectives to be met
3) identify its weaknesses and shortcomings to find practical solutions for optimal delivery of services.
Methods: A comprehensive description of the clinical operations of the program will be discussed.
Discussion: An integrated program in palliative medicine needs efficient clinical operations to ensure various service points deliver the services individuals and families need. Clinical services include the acute inpatient palliative medicine unit, inpatient consultation service, outpatient clinics, and home hospice and inpatient hospice services. Clinical operations include the daily inpatient census list, morning report, weekly interdisciplinary meeting, family meeting, daily teaching, weekly psychosocial rounds, weekend signout, master patient list, problem list, consultation note, outpatient clinic template notes, conference room and nursing station communication boards, monthly administrative meeting, weekly research meetings, weekly grand rounds, clinical, research and educational retreats, and business plans. There are several advantages:
1) Communication between caregivers and patients/families is improved,
2) Quality of care is improved,
3) Research activities are encouraged and can flourish in this environment,
4) Continuity of care is ensured,
5) Clinical services compliment each other and facilitate the financial viability of the program. Limitations and shortfalls of the all aspects of the program are discussed in periodic retreats held several times a year to improve services and plan future program development.
Conclusion: A comprehensive integrated palliative medicine program consists of different service points to ensure that the needs of individuals with advanced illness and their families are met.

FC 05 Education

FC 05.1

Interprofessional education in an in-patient palliative care unit

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Aim: To evaluate the experience of medical, nursing and therapy students undertaking an Interprofessional Practice Placement (IPP) in an In-patient Palliative Care Unit.
Methods: The IPP has been developed to provide a practice learning experience, during the penultimate or final year of health education. Students work as a member of an inter-professional team with a selected group of patients in a live ward setting, under the supervision of qualified staff. Students are given the opportunity to explore and develop their own professional skills, but also demonstrate collaborative practice with other members of the healthcare team. Following a very successful 4 year inter-professional training programme in a local rehabilitation unit, the hospice was approached as a new host site. The IPP placements in the In-patient Palliative Care Unit started in September 2008 and will continue until May 2009. The IPP programme is being run by a generic facilitator (nursing background), medical facilitator and therapy facilitator (occupational therapist). During this period, we will have 6 rotations of 12 students from medical, nursing and therapy backgrounds, coming on 3 week placements.
Results: Qualitative evaluations from students are being collected for each rotation. The evaluations to date are extremely positive, and have highlighted that although this can be a challenging placement, the palliative care setting has given them a great opportunity to observe and participate in real inter-professional learning that will change their future practice. We will present the cumulative evaluations of the IPP placement from the students, and more specifically their experience in the palliative care setting, as well as the lessons learnt by the facilitators.
Conclusion: An In-patient Palliative Care Unit can contribute significantly to inter-professional education for medical, nursing and therapy students.

FC 05.2

What assessment instruments should be used to assess palliative medicine knowledge and attitudes in medical students and doctors? A systematic review

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Aim: Over the last 20 years palliative medicine education has dramatically increased; many courses have been developed and described for medical students and a range of doctors. However, only some of these courses have attempted to assess the impact on participant's attitudes, knowledge, or confidence, and fewer use validated tools to do so. It is becoming increasing important to assess the effectiveness of education and therefore a systematic review was undertaken to
(1) identify instruments which measure palliative medicine knowledge or attitudes in medical students or doctors, and
(2) evaluate the development, validity, reliability, and feasibility of these instruments.
Methods: A systematic search of seven key electronic databases using keywords was undertaken in addition to ancestry searching. The search produced 4783 citations and 164 articles were retrieved and reviewed. 80 studies did not meet the inclusion criteria and 63 studies used non-validated instruments.
Results: 21 studies met the inclusion criteria and were assessed for quality; 9 instruments for use in undergraduates and 13 in postgraduates (one study described two instruments). Some of these instruments have undergone thorough testing while others have been shown to have only face validity or reliability. Of the nine undergraduate instruments, two have undergone some validation to measure palliative medicine knowledge, six to assess attitudes, and one confidence. Of the 13 postgraduate instruments four were identified to assess postgraduate palliative medicine knowledge, three to assess doctor's attitudes towards end-of-life care, five instruments to assess both knowledge and attitudes, and one instrument to rate confidence in key areas of palliative care.
Conclusion: Further details of the instruments and recommendations for the most appropriate

instruments to assess palliative medicine knowledge and attitudes in medical students and doctors will be presented.

FC 05.3

Permanent education for general practitioners and nursing home doctors: Learning in peer groups

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Aims: In The Netherlands, an average general practitioner (GP) is confronted with 4 to 6 palliative care situations a year. That is hardly enough to build up experience in care for the dying. Nevertheless most patients wish to die at home. In The Netherlands a unique and simple education programme has been developed to acquire the necessary knowledge and skills.
Methods: All aspects of palliative care are trained along with consultation and communication skills. The course takes 8 days education and 12 meetings in peer groups in 2 years. The most special about this educational programme is that participants form small fixed peer groups of colleagues supported by a consultant in palliative care. However, the learning does not stop after 2 years. The peer groups continue to meet even after the 2 years of education. During a peer group session palliative case histories are methodologically discussed. The consultant in palliative care adds his/her expertise.
Results: This programme offers GPs 8 days of education and training and a theoretically permanent sharing of experience with peers. Peer group meetings encourage keeping up with the state of the art in palliative care. The first course started in 1997. By now 600 GPs are trained and participate(d) in 90 peer groups. Evaluation shows positive outcomes on knowledge, communication skills and feelings of confidence. A considerable amount of peer groups that ended the course still exist and is active.
Conclusions: Learning in peer group seems successful according to the evaluation, the enthusiastic participation of GPs and the long term existence of a lot of peer groups.
The concept of 'learning in a peer group' for GPs is developed by Bernardina S. Wanrooij, Department of General Practice, Academic Medical Center, University of Amsterdam, Amsterdam, The Netherlands. In cooperation with several Comprehensive Cancer Centres (CCCs), she carried out this programme 13 times. CCC Amsterdam starts in 2009 with the next revised course.

FC 05.4

´Health promotion and public education at the end of life´ - Changing attitudes towards death and dying and breaking the final taboo

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´As a society we do not discuss death and dying´ (End of Life Strategy 2008). The UK government´s End of Life Care strategy gave as one of the objectives to ´increase public awareness and discussion of death and dying´. This area of end of life care is often overlooked or avoided by professionals. This presentation/workshop will present the work of the St. Christopher´s Hospice Health Promotion Projectm which was mentioned in the strategy document as an exemplar of good practice in this field. One of the places public education can happen is in school communities, where we have the opportunity to meet children, teachers and parents. Children from local primary (under 11 years) and secondary (11-18 years) cshools participate in a 4 week project with patients and staff from the hospice and children´s bereavement service in an arts project, which is then exhibited in the hospice before being taken to it´s permenant home in the school. Children and their teachers spend time in the hospice working with patients and members of the arts team, and parents are invited to a celebration at the end of the project. Children are offered the opportunity to meet, talk and create large works of art with dying patients. Parents commented that they were able to overcome their fears and change their own attitudes towards death through their children´s participation and their own attendance at the celebration.
This presentation/workshop will describe the development of the project, how to select, prepare and involve the stakeholders, and how to manage the project from beginning to end.
A ´how-to-do-it´ pack produced for hospices and palliative care units will be shared as part of the workshop, with examples of work from a variety of health promotion projects.

FC 05.5

New resources for teaching palliative care: An evaluation of a blended learning and a face-to-face master course

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Aim: To promote extended basic training in palliative care to health professionals our academic palliative care unit developed in the last five years two pedagogical strategies: a conventional face-to-face master course (12 months) and a blended learning post-graduate intensive course (3 months). Our aim is to evaluate the effectiveness of these different teaching methodologies with a set of similar subjects organized with the same structure.
Methodology: A sample of 234 participants from master courses (N= 89, 20.2% male, 36.0% doctors, 55.1% nurses, 61.8% hospital settings, 29.2% community health centre) and blended learning post-graduated courses (N= 145, 22.8% male, 38.6% doctors, 50.3% nurses, 31.7% hospital settings, 65.5% community health centre), were assessed by: expectancy questionnaire, pre and post- multiple choice test and students course evaluation questionnaire.
Results: There were significant statistical differences between the total scores of pre and post multiple choice test (master course: t=11.56, p<0.0001; blended learning course: t=25.50, p<0.0001) and in all the areas.
Blend learning group showed great satisfaction with the flexibility and the usefulness of the course for their practice.
Conclusions: Blended learning methodology showed the same effectiveness of the master course in the comparable cognitive domains and it is suitable and easy methodology to train large number of teams.

FC 06 Committed to People

FC 06.1

Hospice volunteers in rural communities: An untapped resource for people who are dying, their families and communities

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Little research exists about the role of hospice volunteers in providing end of life care in rural communities. Research does suggest that rural people often seek informal (non-professional) helpers for advice, emotional support, and tangible aid. Given the lack of professional palliative care services in rural communities, hospice volunteers are a valuable rural resource.
Research aim: To document the role of hospice volunteers in providing end-of-life care in one rural community.
Study design: A focused ethnography was conducted in a Canadian rural community (population 2,500) with a well established a hospice volunteer program. Five researchers spent four days in intense fieldwork, interviewing 46 people, including volunteers, clients and their families, healthcare providers, clergy, police, paramedics, and the funeral home director. In semi-structured interviews and focus groups, participants talked about how their community cares for its dying members and about the role of hospice volunteers. Interviews were audiotaped, transcribed, and analysed to identify core themes.
Results: A vibrant culture of natural helping existed in this community and hospice volunteers had a unique role within it. Volunteers feel the pulse of the entire community and quickly mobilize support in times of heightened vulnerability. They are more than a friend to dying people, but not like a professional. They contribute time and companionship; elements which professionals often cannot in under resourced areas. While highly valued, volunteers' contributions to community care are not well understood by professionals.
Conclusions: Hospice volunteers are a crucial link in the network of community care which allows rural people to die with dignity and quality of life, but their role has been inadequately understood by the formal health care system. Our findings point to the need for raising awareness among healthcare professionals of their crucial role in community health.

FC 06.2

Partnership with the police - Bereavement training for the wider community

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St. christopher´s Hospice Candle project has been involved in a major training initiative with the London Metropolitan Police since 2000. When a sudden death such as homicide, suicide or road traffic accident occurs and the police are involved, a Police Family Liason Officer is assigned to work with the family until the case is resolved or closed. these officers did not receive any specialist training until a Public Enquiry 1999 (Macpherson W.) following a high profile unsolved murder case reported that their care for bereaved families was inadequate and needed attention.
The Candle Project was asked to provide the bereavement training as part of a 5 day intensive residential course. there are 14 courses per year, and to date over 1500 officers have been trained. A half day is allocated to bereavement, covering sudden and traumatic death, bereavement theories and the needs of adults and children, based on palliative care training. The courses have all been evaluated, and the teaching on bereavement is consistently rated as the best part of the course.
The outcomes have been:
1. The course model has been adopted for police forces throughout the UK and Eire and has been piloted in Holland
2. The Candle project was appointed as bereavement consultant to the British Government´s Humanitarian Assistance Unit since 9/11World Trade Centre, Bali bombings, SE Asian Trunami and 7/7/ London bombings. The expertise of palliative care professionals was recognised at ministerial level, and impacts directly on the care the bereaved relatives received.
3. Whole communities benefit from greater awareness of the issues around death and bereavement.
The oral presentation will describe the project, and include tips on how to make death and bereavement training acceptable to a lay audience.

FC 06.3

Implementing a comprehensive public health approach to palliative care development in Namibia

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Aims: Palliative care (PC) is still a new concept in Namibia. The African Palliative Care Association is working with local stakeholders to introduce palliative care in a sustainable & culturally appropriate manner. The aim of the program is to create local capacity to expand the coverage & quality of palliative care.
Design: The public health approach to palliative care i.e. Policy, Drug Availability, Education & Implementation, guides the development of PC. APCA is working with the Ministry of Health & Social Services to develop capacity for PC scale up through addressing all 4 components of the approach including
1) conducting a national PC situational analysis
2) integrating PC into relevant government policies, guidelines & standards
3) augmenting PC education & training through local academic & other institutions
4) building capacity of local stakeholders to become PC experts;
5) partnering with Catholic AIDS Action (CAA) to implement PC delivery in a home based program.
Results: The implementation of the public health approach has resulted in an increase in the development of PC in Namibia including
1) the establishment of a national PC task force
2) inclusion of PC in the home based care standards (policy)

3) reviewing the Namibian essential drugs list to include PC medications (drug availability)
4) training in PC including clinical placements & mentorship (education)
5) Implementation of the pilot program with CAA in two sites.
Conclusion: The Public health approach is key to the development of PC & forms an essential framework upon which to base a program along with collaboration with stakeholders.

FC 06.4

Palliative care in Poland in 2008

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Introduction: Poland is a country with 38 million inhabitants. Every year 80.000 patients die from cancer and these patients need palliative care as patients who die from other chronic diseases.
Aim of the study: To outline the present stage of palliative care in Poland and plans to improve current practice. Material and methods: Information from key persons in palliative medicine units in Poland by questionnaire of Experts of project "Best Practice in Palliative Care in Europe" and Annual (2007) Report of National Consultant in Palliative Medicine.
Results: There are over 500 palliative care units in Poland and over 130 in-patient units comprising 970 beds. However there is big discrepancy in distribution of beds between different provinces e. g. in West Pomeranian 1, in Great Poland 8 beds per 100.000 inhabitants. The number of beds is insufficient and previous calculation (50 beds per 1 million inhabitants should be increased to at least 100 beds). Palliative home care is better developed in bigger cities than in rural areas and availability differs 35% - 90% between administrative districts. The aim is to establish at least one palliative home care team in one administrative district and one in-patient unit in 1 - 2 administrative districts. Majority of palliative care units are financed by National Health Fund but resources are insufficient especially for in-patient units (50 Euro per patient per one day). Home care (home hospice) receives about 10 Euro per patient per day but out -patient clinic only 5 Euro per visit. The education and research development are other priorities. Currently 140 doctors are certified as palliative medicine consultants and similarly as nurses specialized in palliative care their number is insufficient.
Conclusions: In spite of Poland 5th place in Europe in palliative care development there are many problems regarding appropriate organisation especially low availability of palliative care services in many rural areas.

FC 06.5

The first Russian Palliative/ Hospice Care Information and Resource Website

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An ageing population, a growing prevalence of cancer, an emerging HIV/AIDS epidemic make a compelling argument for immediate attention to palliative care. The purpose of the project (supported by the Help the Hospices international grant) was to promote palliative care development in Russia and the "Russian speaking countries" by sharing information on news and achievements in the field and encourage people for new services establishment.
The Palliative Care Information and Resource Website was developed. The Website collects and share information about the palliative care history and development, diverse models of care, activities and innovative programmes around the world, International Declarations and guidelines (Recommendation (2003) of the Committee of Ministers ... on the organisation of Palliative Care; The Solid Facts of Palliative Care and Better Palliative Care for Older People, 2005; The Declaration of Venice, 2006; The Budapest Commitments, 2007; New guide on palliative care services for people living with advanced cancer, 2007; Joint Declaration and Statement of Commitment on Palliative Care and Pain Treatment as Human Rights, 2008; The World Cancer Declaration, 2008).
The site contains regularly updated information about the EAPC and HtheH activities and initiatives. It contains all information available in Russia on pain control legislations and starting new palliative care units. An Internet library in Russian for different groups of professionals and public was organized. The site has the link to the CEE & FSU Palliative Care Monthly Email Newsletter for the Palliative Care in Central and Eastern Europe and Former Soviet Union Countries. For the first time we have translated and uploaded in Russian the Document "Euthanasia and physician-assisted suicide: a view from an EAPC Ethics Task Force". The site offers the most important palliative/hospice care links worldwide. It is a working bridge between different countries and regions in Russia.

FC 06.6

User involvement and the cancer experiences collaborative: The work of the research partners forum

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Background: User involvement can help ensure that research is undertaken that reflects user priorities and perspectives. In the UK, the Cancer Experiences Collaborative (CECo), a NCRI-funded Supportive and Palliative Care Research Collaborative, is developing user involvement through engagement with research partners (members of the public and service users). In October 2007 a forum was established to further this work.
Aims: The Research Partner Forum has two aims.
1. To support individuals to become involved in the development of CECo initiated projects;
2. To develop new research proposals, seek funding and undertake user-led studies.
Methods: Monthly meetings, facilitated by a CECo Research Fellow, are held to provide a regular contact between the research partners and CECo researchers. Further involvement occurs through specific project meetings and training events. An annual review is undertaken to identify the benefits and challenges of this work.
Results: The forum currently has 9 members with a range of backgrounds, personal experiences of life-threatening illnesses and caring responsibilities. To date, 10 meetings have been held since October 2007. Forum members have also attended research training (2 people), research conferences (3 people) and advice has been provided on 7 proposals. The Forum has also developed its own research proposal and submitted it for funding.
Conclusions: There are important benefits to CECo of this initiative in ensuring that their research programme is informed and shaped by user views. However, challenges exist regarding the demands placed upon individuals and resources required to sustain the involvement of all parties. User involvement requires an investment on the part of researchers and research partners in order to develop effective, sustainable relationships. Only then will quality research projects be developed that appropriately reflect user perspectives.

FC 07 End of Life Care

FC 07.1

End of life care initiatives in the UK: How do the four nations differ?

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Background: The promotion of good end of life care within primary care has been the subject of several initiatives in the United Kingdom; such as the Gold Standards Framework, and the Liverpool and All-Wales Care Pathways. National guidance on supportive and palliative care for adults with cancer has emphasised organisational changes, and strategies to implement them have differed between the four nations of the UK.
Method: Using a self-complete postal questionnaire to a random sample of GP practices in the whole of the UK, we aimed to assess uptake of end of life care initiatives and concordance with guidance in the four nations. We prepared statistics on initiative uptake, and calculated a summary measure of concordance with guidance: the General Practice End of Life Care Index (GP-EoLC-I).
Results: 2096 questionnaires were returned (60.0% response rate). In Scotland, 80.9% of practices reported participation in the Gold Standards Framework; in England 62.4%; in Northern Ireland 27.49%, and in Wales 16.0%. Reported use of the Liverpool or other Care Pathway by practices was 27.9% in England, 11.9% in Scotland; 9.6% in Wales, and 8.2% in Northern Ireland. Calculations of the mean scores on the GP-EoLC-I showed differences among the four nations (F=2.874; p=0.022) The mean score for England (mean=30.95; 95% confidence interval (CI)=30.51,31.39; n=1336) was significantly higher than the mean score for Wales (mean = 28.54; 95% CI = 26.64,30.43; n=67) and was significantly lower than the mean score for Scotland (mean = 32.10; 95% CI = 31.09,33.11; n=201). The mean score for Northern Ireland (mean = 29.71; 95% CI = 27.64,31.77; n=55) was significantly lower than the mean score for England.
Conclusion: The implementation of End-of-life care initiatives shows great variation between the four UK nations, reflecting strategic and policy differences. Further work is required on the extent to which differences between nations impacts on clinical outcomes.

FC 07.2

Does Liverpool Care Pathway for the dying patient (LCP) in hospital make the difference? Results from a before-after intervention trial

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This is a before-after intervention trial, primarily designed to evaluate some process and outcome hospital end of life care indicators.
All consecutive cancer deaths occurred in the Medicine ward of Villa Scassi Hospital in Genoa (Italy) were registered in the 4 months before and in the 4 months after LCP implementation. A multiprofessional Palliative Care Team performed the LCP implementation.
The non-professional caregivers were interviewed using the Italian version of the Toolkit After-Death Family Member Interview, developed and validated in USA to measure quality of care at end of life from the unique perspective of family members. The Italian version includes 34 questions, whose results can be summarized in 7 scales. For the purpose of this analysis, each scale score was linearly transformed such that all scales range from 0 to 100, with a higher scale score representing a higher quality of care.
Overall, 82 cancer deaths were identified (49 before and 33 after). We could not find 3 caregivers, 1 patient was without any caregiver, and 17 caregivers refused to be interviewed. We interviewed 37 (75.5%) caregivers before and 24 (72.7%) after the LCP implementation.
A substantial improvement (mean improvement; 95% CI) in all the Toolkit scales was observed in the sample after LCP implementation as compared to the sample before implementation: information to the patient and the family (+16.0; 95% CI: -1.0 and 33.6); patient care planning (+33.3; 95% CI: -18.0 and 85.0); focus on the individual needs of the patient (+18.7; 95% CI: 2.2 and 35.3); emotional needs of family (+16.7; 95% CI: 3.9 and 29.4); coordination of care (+19.4; 95% CI: 6.6 and 32.2); self-efficacy of the family (+16.7; 95% CI: 0.1 and 33.3); overall quality of care (+10.5; 95% CI: -3.0 and 24.0). These results strongly suggest that the introduction of the LCP in an hospital setting might markedly improve the quality of end of life care provided to cancer patients.

FC 07.3

Comparing the illness experience of patients with cancer and non-cancer diagnoses

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Aim: Specialty care is increasingly used to manage patients with diagnoses of advanced illnesses. Cancer has received exceptional attention to relieve the burdens of the illness experience. The purpose of this paper is to present analyses comparing cancer and non-cancer diagnosis on multidimensional outcomes such as functional status, emotional well-being, spiritual well-being, and quality of life. We then model whether diagnosis or other demographic factors such as education, income and social support are stronger predictors of quality of life while living with advanced serious illness.
Methods: A prospective panel of 210 seriously-ill patients and their caregivers interviewed monthly for up to 4 years or death. Eligible patients had Stage IV cancer, advanced CHF (EF <20) or advanced COPD FEV1 < 1l.), and were identified using clinical databases from one geographic region. Baseline measures: gender, ethnicity, education, financial well-being, marital status, and diagnosis; Profile of Mood States, Centers for Epidemiological Study of Depression scale, Rosow-Breslau ADLs, FACIT physical, social, psychological, spiritual well-being sub-scales.
Results: Patients outcomes of physical, social, emotional and spiritual well-being did not differ by diagnoses. Patients with non-cancer diagnoses exhibited poorer functional status, higher anxiety, and greater depression that panel members with cancer. In multivariate models, demographic factors such as education and financial situation were more strongly associated with illness outcomes than were diagnostic category.
Conclusion: Despite heightened attention to the needs of patients with cancer, community dwelling persons with non-cancer advanced illness had more severe functional impairment and anxiety and depression. Furthermore, when compared in multivariate models, social factors such as financial situation were more strongly associated with poor outcomes of anxiety and depression and lower quality of life than diagnosis.

FC 07.4

Key aspects of support for family carers in the last months of end of life care at home

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Aim: Family carers play a crucial role in end-of-life care at home. Nursing support is important to carers, but it is unclear which aspects they see as most valuable to themselves. This study investigates views of family carers on key support factors in the final months of life.
Methods: 75 family carers of deceased patients referred to five UK Hospice at Home services, six to nine months post bereavement. Nine focus groups (FGs), with four to eight participants, lasting one and a half to two hours plus 22 semi-structured telephone interviews with carers unable to attend FGs. Carers were asked to identify key aspects of support received and shortfalls in provision. FGs and interviews were audio recorded and transcribed verbatim. Data were analysed thematically using framework analysis approach.
Results: Carers identified three main support categories.
First was support that 'enabled the carer to care': input and assistance from health professionals that ensured they were better equipped to care for the patient. Key aspects included a contact person for access to advice and services, particularly out of hours, support with managing symptoms and medications and information about disease progression, prognosis and the dying process.
Second was direct support for the carers themselves, particularly overnight respite, a break in the day and opportunities to talk about their own feelings.
Third, the way in which support was delivered: involving the carer in all aspects of the care process, offering resources in anticipation of need, co-ordination and communication between different agencies involved in care and the importance of having a relationship / trust in health professionals.
Conclusion: Carers have considerable need for support when looking after someone at home towards the end of life. However, this support needs to be sensitive to carers' perceptions about their role and responsibility in the patient's care.
Funding: Burdett Trust for Nursing UK.

FC 07.5

Patients known to specialist palliative care are more likely to die at home

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Objectives: To determine which Mount Vernon Cancer Network (MVCN) patients are known to specialist palliative care services before they die, and to investigate their place of death.
Methods: Data was requested from the Thames Cancer Registry and the Eastern Cancer Registry and Information Centre for MVCN patients dying between July-December 2003. MVCN community specialist palliative care services (SPC) undertook a data matching exercise to identify those patients known to their services. Data was analysed using Microsoft Excel. Results were fed back to participating SPC services.
Results: A total of 11/12 MVCN SPC services took part in the exercise. A total of 1895 cancer patients died in the MVCN in this period, of whom 862 (45%) were known to SPC services. Patients most likely to access SPC were those registered with brain tumours (62%) and respiratory malignancies (57%), whereas only 36% of patients with haematological malignancies accessed SPC. Those over 75 years of age were less likely (34%) to be known to SPC than younger patients (59%). Cancer patients known to SPC services were less likely to die in hospital (29%) than those who were not known (61%) to SPC.
Conclusions:
1. Cancer registry data provides a useful data set for SPC services to investigate access to SPC support and place of death, both priorities identified by NICE and the National End of Life Care Programme.
2. Older patients are less likely to access SPC support.
3. SPC services may have a significant impact on reducing deaths in hospital. SPC may therefore enable patient choice as few people express a wish to be cared for in hospital when asked their preferences for end of life care.
4. The collaborative approach to the survey enabled local bench-marking of access to services.
5. Difficulties included interpreting place and cause of death from death certification data.

FC 07.6

Biological prognostic factors of survival in a palliative care unit

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Aim: The aim of this study was to develop the understanding of biological predictive factors in the field of palliative care. This prospective monocentric study considered a cohort of 246 terminally ill cancer patients admitted in a palliative care unit from January 2004 through June 2006.
Methods: Twenty-one currently utilized biological factors, previously described in the literature as being potentially predictive of survival in the studied population, were chosen to be analysed. The two statistical methods used were the Kaplan-Meier Survival Curves, using the log-rank test and the Univariate and Multivariate Logistic Regression Analysis (ULR and MLR) using the odd-ratio, in which the outcome variable is the onset of death within 15 days.
Results: 133 men and 113 women were analysed (median age: 64.4; range: 18-93.7). The median of survival was nine days. A poor prognosis was predicted in both statistical methods by the following five parameters: low Karnofsky performance status (log-rank: p<0.0001; ULR: p<0.001; MLR: p=0.004), high total white blood count (log-rank p=0.0003; ULR: p<0.001; MLR: p=0.012), high aspartate aminotransferase (AST) levels (log-rank p<0.0001; ULR: p<0.001; MLR: p=0.007), high lactate dehydrogenase (LDH) levels (log-rank p=0.0019; ULR: p=0.008; MLR: p=0.03) and high prognostic inflammatory and nutritional index (PINI) (log-rank p=0.0013; ULR: p=0.001; MLR: p=0.033).
Conclusion: The individualisation of biological prognostic factors is a conclusive step to improve patients' prediction of survival but complex ethical issues regarding clinical decision making and the physician's duty to inform the patient are challenging their application in a palliative care unit where the median of survival is nine days. How can we use a quantity of life prediction tool at a moment where quality of life seems the most important in patients' care? What is the signification of statistical data for a dying patient?

FC 08 Ethics in Palliative care

FC 08.1

Understanding refusal of therapy: Agreeing on a way forward

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This study examines how nursing and medical staff deal with patients' refusal of medical treatment in acute care hospitals, in order to understand current practices and investigate their sufficiency to address patient wishes regarding boundaries of acceptable care.
Aims: The study sought to identify the main constraints confronting nursing and medical staff, and to explain the key factors that moderate the processes of dealing with patients who are suffering from serious illness, when they refuse treatment.
Design: Utilizing a grounded theory method, a sample of 18 nurses and 6 medical practitioners from two tertiary public hospitals were interviewed and observed during a three month period. In addition, the patient records were also examined.
Results: The key social problem shared by nursing and medical staff is conceptualized as Competing Perspectives: Encountering Refusal of Treatment. This problem reflects the diverse perceptions and beliefs that confront participants when patients decide to forgo therapy. The key patterns of response that emerged were identified in four categories Seeking Clarification, Responding, Advocating and Influencing and these represent both positive and negative reactions to patients and their families. Furthermore, there are several determinants that either augment or restrict the processes adopted by the participants, such as the design and organization of work.
Conclusion: There is an important need to consider the effects on patients and relatives, who tend to rely heavily on the guidance of, and react to health professionals, regarding the processes associated with decision-making. Where health professionals lack understanding or when fundamental principles are not observed, then patients and their families are potentially prejudiced and denied the safeguards meant to support and allow them to exercise their right of choice.
Funding: This research was undertaken as an unfunded PhD project.

FC 08.2

Community specialist palliative care nurses views on advance care planning

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Aims: Advance Care Planning (ACP) attempts to help patients, their carers and health professionals discuss preferences and wishes for care at the end of life. Despite a very limited evidence base, this practice is being advocated as policy and part of routine palliative care in some European countries. We aimed to understand the views of palliative community clinical nurse specialists (CNS) on the extent of the current practice of establishing patient preferences for care at the end of life and to explore their attitudes to using a more structured approach to ACP in patients referred to them by general practitioners.
Methods: Three focus groups were conducted with purposively selected specialist palliative community nursing teams working in three different geographical areas. One team (ten participants) additionally participated in individual semi-structured interviews. Focus groups and interviews were digitally recorded, transcribed and analysed utilizing NVivo.
Results: Palliative CNS currently believe exploring patients' wishes and preferences for care at the end of life is an inherent part of their professional role. Rapport building, establishing trust and taking the patient lead were identified as being essential to the success of their current routine practice. They identified however areas where communication is challenging while undertaking these discussions; managing family

conflict , dealing with denial, and the possible raising of expectations concerning preferred place of care.
Conclusions: A more structured approach to ACP was viewed positively as a way of improving the recording and documentation of patients' preferences. However, reservations were expressed that adopting this approach routinely encourages a check-list approach ignoring the intuitive nature of current practice and the flexible and advanced communication skills required. Such tools must be used sensitively to avoid conflict within the patient, relative and professional relationships.

FC 08.3

Ambivalence towards dying. How to understand patients' wishes ethically

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Aims: Clinical experience and empirical studies have shown that a wish to die of terminally ill patients is frequently not constant but presents itself as a fluctuating, often hypothetical consideration that goes typically along with an expressed ambivalent attitude. Caregivers might experience such ambivalent attitudes as puzzling or challenging. Some tend to see them as signs of inconsistency or of temporary confusion. Patients can be unaware of their ambivalence or experience it as burdensome. While triggering factors of a wish to die have been discussed in the literature, the complex structure of decision-making from the perspective of the patients and the role of ambivalence remains unclear.
Methods: A philosophical-ethical analysis of the experience and meaning of ambivalence using a phenomenological-hermeneutical approach, based on evidences from an ongoing, extensive qualitative interview-study with patients in palliative settings, their caregivers and relatives.
Results: Ambivalence can be formally defined as competing feelings or emotions due to expectations about how individuals should act, think or behave. Preliminary results of this study indicate that non-pathological, commonly experienced ambivalence is an integral part of personal preparations for dying. Both patients' and caregivers' narratives indicate practical meanings and roles that ambivalence can have. Based on this we try to explain how these existential conflicts are related to or caused by conflicting normative expectations within a texture of social interactions.
Conclusions:
(i) Two aspects of ambivalence can be distinguished: subjective (conflicting moral claims on a personal level) and structural (presumed social expectations).
(ii) Better understanding the ethical meaning of ambivalence improves the care for persons with an ambivalent wish to die.
Funding: Oncosuisse/Swiss Cancer League, Bangerter-Rhyner-Stiftung.

FC 08.4

Medical futility at the end of life as perceived by intensive-care and palliative-care clinicians

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Aims: Medical futility at the end of life ranks among the most difficult challenges of medicine. Empirical data on the topic is scant. Our goals were to elucidate how clinicians in palliative care and intensive care define medical indication and when they perceive life-sustaining treatment (LST) to be futile. We also wanted to know how they communicate futility and why LST is often continued despite being futile.
Methods: We conducted semi-structured interviews with 18 physicians and 11 nurses from palliative and intensive care units. The transcripts were analyzed according to Qualitative Content Analysis.
Results: The definition of medical indication posed difficulties. It was mostly associated with the presence of "reasonable" and "meaningful" goals of care that offer the patient a benefit regarding quality of life. This benefit, however, should be proportionate to the risks, harms and costs. Clinicians did not see an indication for LST (futility) in the following situations: irreversible dependance on LST, advanced metastatic malignancies and fatal brain injuries. Physicians and nurses agreed that the indication should be assessed by the treating physicians after consultation with the care team. Intensive care clinicians favoured disclosing the prognosis in a stepwise fashion. Palliative care clinicians focused on a straightforward and honest information strategy, assessing the patient's and family's understanding and showing empathy. The reasons for continuing futile LST are primarily seen as emotional: guilt, mourning, hope for miracles, helplessness, fear of legal punishment and fear of the patient's or family's response. Other identified obstacles were: organizational routines, professional ethics, insufficient legal and palliative knowledge, and requests for treatment by patients or families.
Conclusion: Managing futility could be enhanced by communication training, knowledge transfer, organizational improvements, and emotional and ethical support systems.

FC 08.5

Needs assessment for palliative care services in rural areas: High uncertainty regarding ethical and legal questions

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Introduction: In a project assessing palliative care needs in rural areas in south-eastern Bavaria, special emphasis was given to the level of knowledge of health care professionals concerning ethical and legal questions at the end of life.
Methods: A specifically developed questionnaire was sent to general practitioners and physicians in hospitals as well as to head nursing staff (in hospitals as well as in nursing homes and outpatient nursing services). Respondents were asked to answer yes or no to the following question: "For seriously ill patients, are physicians legally obliged to provide the following treatment in all cases?" The treatments were: administration of fluids or nutrition, hospitalization for ileus or bleeding, cardiopulmonary resuscitation (CPR), oxygen, and pain treatment. The correct answer for all treatments is no.
Results: 235 questionnaires were returned (150 physicians, 85 head nurses; return rates 38% and 71%, resp.). The results show a clear lack of knowledge in all areas. The following percentages of respondents wrongly indicated that physicians are legally required to administer fluids to terminally ill patients: general practitioners 56%, hospital physicians 39%, hospital head nurses 92%, outpatient head nurses 37%, nursing home head nurses 37%. The overall difference between physicians (48%) and head nurses (69%) is significant (p=.004). Similar results were found for the other treatments (% of wrong positive responses): nutrition, physicians 14% vs. head nurses 22%, n.s.; hospitalization for bleeding, 27% vs. 65%, p<.001; hospitalization for ileus, 39% vs. 71%, p<.001; CPR, 8% vs. 28%, p<.001; oxygen, 40% vs. 64%, p=.001; pain treatment, 86% vs. 91%, n.s.
Conclusions: There are widespread uncertainties with respect to ethical and legal obligations during the terminal phase. To address this major problem in palliative care practice, improved education in palliative care, and competent hospital and outpatient support teams are needed.

FC 08.6

Legal practice of euthanasia in Belgium. Analysis and interpretation of the last three years registration documents and the experience of a supportive care unit

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The Belgian law relative to euthanasia prescribes that a physician performing an euthanasia has to complete a registration document to the Federal commission for control and evaluation of euthanasia. We analyse 924 reports from January 2006 and December 2007.The most frequently reported diagnosis remains cancer in 81% of cases and neuromuscular illness in 9%, in 80% of cases, the age of the patients is between 40 and 79. The place where euthanasia was performed is: 49% at home (by a general practitioner :45%) and 50% in a hospital. The method used in more than 90% of cases is an intravenous injection inducing unconsciousness followed, if needed, by an intravenous injection of a neuromuscular relaxant. Euthanasia requests were mostly related to severe dyspnea, GI occlusion, lost of hope, fear of intractable pain, lost of dignity. The important and recurrent difference in the number of registration documents written in French (14%) and those written in Flemish (86%) will be analysed and discussed. This seems to be due in part to cultural differences.In our supportive care unit, 25 requests for euthanasia were followed (3 in 2006, 6 in 2007, 16 in 2008 (end September)). Among them 13 led to euthanasia according to the Belgian law. (10 at hospital and 3 at home). We met the same clinical and symptomatic conditions as the rest of the country. Furthermore, there were no suicidal ideation and no "intractable depression". Each patient was seen by our psycho oncology team and all symptoms received adequate treatment with an optimal relief (auto- and hetero-evaluations). All cases have been reported (in French) to the Federal commission. More specific data (Age, tumors, symptoms evaluation, etc.) will be presented. Our experience confirms that Belgian law meets medical expectations in terms of end-of- life decisions and euthanasia. More than fifty cases are reported every month. Supportive care, palliative care and euthanasia are complementary.

FC 09 Psychology and Communication

FC 09.1

Evaluating palliative care patients' meaning in life using the Schedule for Meaning in Life Evaluation (SMiLE)

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Background: With life limiting illness, meaning in life (MiL) becomes a prominent topic. If MiL is lost, desire for hastened death or euthanasia may occur. The Schedule for Meaning in Life Evaluation (SMiLE) has been developed to assess this highly individual construct, and was validated with a student sample as well as a representative sample of the German population. Data from palliative patients are contrasted with the normative data.
Methods: Participants are asked to name 3-7 meaning-providing areas. Each area is rated by the patient in terms of its importance and current level of satisfaction. Indices of importance (range 20-100), satisfaction (0-100), and weighted satisfaction (SMiLE-index, 0-100) are calculated. The named areas are grouped into 13 content categories, derived from analysis of the representative data.
Results: 100 patients completed the interview and named on average 5.3±1.6 meaning-providing areas. The index of satisfaction was 70.2±19.7, the index of importance 84.7±11.5, and the SMiLE index 72.0±19.4. The representative sample (N=977) named fewer meaning areas (3.8±1.4, p<.001), and showed higher levels of satisfaction (82.8±14.7; p<.001) and weighted satisfaction (83.3±14.8; p<.001). Palliative patients were more likely to name partnership, nature, and spirituality as meaning-providing areas, while the general population was more likely to name work and health. While palliative care patients were as satisfied as their healthy counterparts with family, partnership, and spirituality, they showed lower levels of satisfaction with health, hedonism, and work.
Conclusion: Palliative care patients name more meaning-providing areas than the general population, but are overall less satisfied with them. New methods are needed to help palliative patients to safeguard their MiL. The SMiLE can be used as a tool to identify individual meaning-providing areas, which can then form the basis for targeted interventions to improve subjectively perceived MiL.

FC 09.2

Communication on spirituality and religion by doctors in palliative medicine - a questionnaire based study in the UK and Ireland

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Aim: To better determine the influences on Palliative Medicine Physician (PMP) communication on spiritual and religious issues. Previous U.S. studies suggest several factors that can influence doctors' communication on spiritual and religious issues, but the attitudes and

practices regarding such communication has not been specifically studied among PMPs.
Method: A questionnaire was posted to all 828 PMPs registered with The Association for Palliative Medicine of Great Britain and Ireland. The questionnaire, developed with an expert Advisory Panel, consisted of 24 items employing tick-box responses, Likert scales and 0-10 rating scales.
Results: The overall response rate was 72% (599). The % of PMPs who rated spiritual and religious inquiry as important was high (95% and 84% respectively). PMP self reported rates of spiritual inquiry were "often" 50% and "sometimes" 38%; religious inquiry was "often" 40% and "sometimes" 37%. PMPs rated comfort in discussion on the higher end of a 0-10 rating scale (median scores of 8). Comfort scores were poorly correlated with frequency of inquiry into spiritual and religious concerns (r=0.48 and r=0.41 respectively). If spiritual concerns were not discussed, influences included patient preference (66% c.f. 61% for religious concerns) and lack of time (44% c.f. 34% for religious concerns). In PMPs who classified themselves as "religious", there was a poor but significant correlation between self reported importance of personal religion and inquiry frequency into spiritual (r=0.13 p=0.002) and religious (r=0.19, p<0.0001) issues; similar findings were found with comfort scores for discussing spiritual (r=0.14, p<0.0001) and religious issues (r=0.23, p<0.0001).
Conclusion: This is the first large scale study to explore PMPs attitudes and practices for communication on spiritual and religious issues. There was a high response rate, the vast majority viewing spiritual and religious inquiry as an important part of their clinical practice.

FC 09.3

Prediction of physicians' ability to detect patients' distress

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To test the hypothesis that physicians' characteristics (socio-demographic, professional and psychological) and interviewing skills in a highly emotional simulated patient interview (communication skills, psychological stress and physiological stress) may predict physicians' ability to detect patients' distress accurately.
Physicians' detection of patients' distress was assessed during a half-day of actual patient interviews. Physicians' socio-demographic, professional and psychological characteristics were assessed by questionnaires. In a highly emotional simulated patient interview, physicians' communication skills were analyzed utterance by utterance according to a specifically designed software (LaComm), physicians' psychological stress was assessed by questionnaires and physicians' physiological stress was assessed through heart rate and blood pressure recordings.
Ninety-four physicians and 442 inpatients were included. Thirty percent of the variance in physicians' detection of patients' distress in actual patient interviews was explained by some physicians' interviewing skills recorded in the highly emotional simulated patient interview: physicians' self-reported anxiety level before task (r=-.21; p=.040), physicians' mean arterial blood pressure level before task (r=-.26; p=.019), physicians' mean heart rate during task (r=-.21; p=.043), physicians' use of empathy during task (r=.23; p=.027) and the evolution in physicians' mean arterial blood pressure between pre-task rest and post-task (r=-.27; p=.012).
Physicians' ability to stay empathic in a highly emotional simulated patient interview and physicians' ability to manage their stress before, during and after this task predict their ability to detect patients' distress accurately in their clinical practice. Future training programs focusing on distress detection should be aimed at helping physicians improve these two abilities. This procedure will be used in context of end-of-life decisions.

FC 09.4

Providing spiritual care in multi-cultural Europe: Meeting the needs of African patients

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Context: Increasing numbers of African nationals are migrating to EU countries (>2.25 million in 2003). Spiritual support is a key component of palliative care, but meeting policy guidance has been hindered by a lack of understanding of spiritual needs among immigrant populations.
Aim: To investigate the spiritual beliefs and needs of palliative care patients in sub-Saharan Africa (SSA), and inform service provision in SSA and Europe.
Methods: Cross-sectional, semi-structured qualitative interviews with a purposive sample of patients recruited by research nurses at 4 palliative care sites (3 South African, 1 Ugandan). Interviews were recorded, transcribed and translated into English for thematic content analysis.
Results: 72 patients were interviewed in 7 languages (Zulu, English, Xhosa, Luganda, Runyoro, Sotho, Tswana). Mean age 45.1 (SD 15.9); 48 (66.7%) were female; 29 (40.3%) had cancer; 43 (59.7%) were HIV+. >20 different Christian denominations were reported. Intrinsic aspects of faith (e.g. personal prayer) and extrinsic aspects (church attendance, 'revivals' in hospital) were described. Syncretism with traditional ancestral beliefs was reported; a minority were non-Christian (Muslim, Hindu, spiritual but not religious, atheist). Faith helped provide peace, hope and acceptance of disease; however, spiritual crises were also described (disillusion with the church, bitterness towards God, questioning one´s faith). Uncontrolled pain, social rejection and family worries were barriers to spiritual peace. Some patients saw their doctors as spiritual guides.
Conclusion: For patients in this study, illness experiences were mediated through spiritual faith and practice. Given migration trends it is vital to understand the needs of African patients, for whom spirituality is likely to be key to quality of life. Recommendations are made for service providers in Europe and SSA, e.g. proactive discussion of faith, access to African faith leaders, staff training.

FC 09.5

The desire to hasten death as a function of reducing psychological distress

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Background: The desire to hasten death of terminally ill patients is receiving more and more attention in palliative care literature. This study wants to decode the communicative function and aims to identify the patients' expectations towards their caregivers. The first step of the project is to map psychological processes of patients with a desire to hasten death.
Methods: Patients from the palliative care units in Aachen, Bonn and Cologne who report a wish to die or ask for physician-assisted suicide are questioned about their perceived reality with an open, semi-structured interview guideline. Interviews are audiotaped and transcribed verbatim. Attitudes towards life and death and their biographic contexts are central aspects of the interview. Seven patients have been interviewed so far. Grounded Theory was used for analysis.
Results: The most common category was avoidance of agony. Within this category patients´ statements describing powerful inner pictures of fright were summarized. Patients´ statements were e. g. "I see myself starving", "dying process is lying around for months" or "I'm afraid of dying in agony, crying and screaming". All these thoughts are characterized by anticipating and constructing future states of one self. The desire to hasten death is reported as a attempt to avoid anticipated future states of one self.
Conclusions: Several hypotheses are generated:
1. Patients with high availability of scaring pictures anticipate high emotional distress in their future.
2. The anticipated suffering overlays the present state of being.
3. The content of the anticipated pictures interferes with basic self concepts.
These hypotheses are elements in creating a theory about the desire to hasten death in patients receiving inpatient palliative care. Next step is to integrate and differentiate these suggestions with respect to other results of the study.

This study is supported by a grant of the Deutsche Forschungsgemeinschaft (DFG, 350253).

FC 09.6

Older people with a wish to die

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Aim: The aim of this study is to determine the prevalence of death ideation among older people in the Netherlands, and to determine the association of death ideation with depressive symptoms and other possibly relevant factors.
Methods: In the Netherlands 1794 people aged 58-98 years were interviewed at their home in 2005/2006 (Longitudinal Aging Study Amsterdam).
Results: 81.3% of the respondents said they had never had death thoughts or wishes; 15.3% said they had had such thoughts or wishes; 3.4% said they currently had a wish to die or had only a weak or no wish to continue living.
People who had a current wish to die had clinically relevant depressive symptoms (CES-D≥16) in 68% of the cases (vs. 32% of people with death ideation ever; 9% of people who never had death ideation), but actually suffered from a depressive disorder (DIS interview) in only 20% of the cases (vs. 5% if death ideation ever; 0.3% if never death ideation).
In a multivariate analysis a current wish to die was associated with having depressive symptoms, a depressive disorder, a speech impairment, a visual impairment, being divorced or widowed, and having a smaller network. Furthermore, in people aged 58-70 years, financial problems, experiencing pain and recent life-events were associated with a wish to die, in people ≥70 years, loneliness and involuntary urine loss were associated.
Conclusion: It seems there are two different subgroups of older people with a wish to die: people who have a (subthreshold) depressive disorder, and people who have other reasons for having a wish to die. This distinction can be relevant for further research and for health care professionals. The practical implication for health care professionals is that a wish to die does not necessarily mean that someone has a depressive disorder, but it should be a trigger to investigate whether this is the case, and treat depression if present.

FC 10 Organisation of Services

FC 10.1

Access and referral to palliative care in seven European countries, an EU perspective

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Background: Palliative care may not be reaching all of those that could benefit from it. There is an urgent

need to evaluate and improve access and referral to palliative care and to identify the barriers or incentives to providing and receiving palliative care. In cooperation with 7 participating partner organisations in 7 European countries (Belgium, England, France, Germany, Netherlands, Poland, and Spain) an international study is being undertaken in order to describe 'best practices in palliative care' and to develop quality indicators.
Aims: To describe and compare access and referral (barriers and incentives) to palliative care in seven European countries.
Methods: Experts in each country were asked to complete an inventory. A review of the literature was also undertaken by researchers in each country.
Results: Data has been collected and will be presented for all seven European countries. In the UK several barriers to access and referral to palliative care were identified including lack of knowledge and education amongst health and social care professionals, and a lack of standardized referral criteria. Some groups of people failed to receive timely referrals e.g. those from minority ethnic communities, older people and patients with nonmalignant conditions as well as people that are socially excluded e.g. homeless people.
Conclusions: There is a need to improve education and knowledge about specialist palliative care and hospice care amongst health and social care professionals, patients and carers. Standardized referral criteria need to be developed. Further work is also needed to assess the needs of those not currently accessing palliative care services. A set of indicators will be established and used to assess palliative care, define best practices and compare specific aspects of the palliative care provided both within and across the seven European countries.
Funding: EU supported via the PHEA (Public Health Executive Agency) in 2007.

FC 10.2

Which cancer patients die at home? A study of six European countries using death certificate data

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Background: To enable dying at the place of wish we need to know which patients are dying where and for what reasons. This study aims to examine the proportion of cancer deaths occurring at home in six European countries in relation to illness, demographic, and healthcare factors.
Methods: We analyzed death certificate data of all cancer related deaths in 2002 in Italy and 2003 in Belgium, The Netherlands, Norway, England, and Wales (N=231,276). Data were linked with regional healthcare statistics and area characteristics. Multivariate binomial logistic regressions were performed to examine factors associated with dying at home.
Results: The proportion of all cancer related deaths occurring at home, ranged from 12.8% in Norway to 45.4% in the Netherlands. Type of cancer and being married influenced the probability to die at home in the same way in all countries. Older age and being female were associated with lower odds of dying at home, except in Italy where the opposite was the case. A higher educational attainment (not available in the Netherlands, England, and Wales) was in all countries and a less urban municipality of residence in all countries but England associated with better odds of dying at home. Number of hospital and care home beds seemed not to be universally strong predictors of dying at home.
Discussion: There are large differences between countries in the proportion of cancer patients dying at home. Cancer type and marital status had the same effect in all studied countries, and may be less amenable to policy interventions. The fact that the effects of factors such as age, sex, educational level and level of urbanization varied considerably between countries suggests that country-specific cultural, social, and health care organizational factors play an important role in determining where patients die.. Better understanding of these factors would inform evidence-based health policies aimed at increasing patients' chances of dying at home.

FC 10.3

A survey among Austrian oncologists about their attitudes towards palliative care for patients with primary metastatic cancer

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Aim: Cooperation between oncologists and palliative care physicians is essential for continuity of care of patients with cancer. Attitudes towards palliative care services and issues has not been investigated in Austrian oncologists.
Methods: we performed a survey among 785 medical, surgical and gynaecological oncologists in Austria in which we presented the clinical course of a patient with primary metastatic breast cancer from diagnosis until death. Oncologists were asked to indicate at what point in time they would involve palliative care services and hospice services and when they would inform the patient about incurability of her disease and her reduced life-expectancy and about the possibility to issue an advance directive.
Results: The majority of 176 responding oncologists would involve palliative care services when the patients Karnofsky index (KI) was >50 and hospice services when the KI was > 40. Special training in palliative care was significantly associated with an early-on use of hospice services. Reasons for not involving palliative care and hospice services earlier than indicated were systematically evaluated and included among others "fear to destroy patient's hope" (36% palliative care, 57% hospice). Sixty seven percent of participating oncologists would inform the patient about her prognosis and life expectancy at the time of diagnosis while issuing an AD was brought up by 25% at that time.
Conclusion: Our data show, that oncologists involve palliative care services at an advanced stage of patients with primary metastatic cancer and deliver information on incurability of disease rather early on.

FC 10.4

What happens after dark? Improving "after hours" palliative care planning in urban and rural Australia, for patients, their carers and health professionals

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Aim: This three year project, funded by the Department of Health and Ageing has four main aims: to investigate current after-hours palliative care in rural and urban Victoria; to develop strategies to enhance after-hours palliative care planning; to test and evaluate these developed strategies; and to make recommendations to support policy and practice development.
Methods: The study was conducted in 3 phases. In phase 1 a total of 38 interviews were conducted with general practitioners, palliative care nurses and recipients of care in three general practice areas, incorporating both urban and rural areas. These were thematically analysed and identified many workforce issues. These findings were then used to construct a wide-ranging survey sent to nurses (125) and GPs (525) for phase 2. Drawing on the results of both phases 1 and 2, phase 3 has involved the development, trial and evaluation of information and educational resources to enhance aspects of support for after hours care.
Results: All data were analysed and identified significant challenges in after-hours care. Major workforce issues identified in phase 1 and supported by phase 2 data included: access to palliative care training, information about relevant Medicare items, advanced care planning issues, shortage of appropriately trained staff for after-hours on-call services, staff safety, availability of GPs after-hours and multi-disciplinary team communication issues. Some of these issues have been addressed in the information and educational resources developed.
Conclusion: Information and educational strategies, will improve aspects of after hours care. These resources will utilise already existing websites and educational programs for medical and nursing professionals, so enhancing their knowledge of the provision of after-hours care.

FC 10.5

What keeps a palliative medicine physician so busy with patients? Time expenditure in palliative care

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Palliative care physicians seem to spend a lot of time seeing a small number of patients. What do they do with that time? There has been little relevant information in published literature. We carried out a pilot study aimed at presenting the differences in clinical time spent among physicians working in a Palliative Care Unit (PC) and in a Medical Oncology Department (MO) at a teaching hospital.
An external observer carried out exhaustive tracking, firstly of two PC physicians, members of a consultation team, and later of three MO physicians, members of the gastrointestinal-oncology team. Over a number of working days, the distribution of working time was noted with patients, with families, with other physicians, with nurses on the ward, team work, checking records, prescribing medication, walking or waiting and other tasks. Non-clinical time, research, teaching, others, was excluded from the clinical time. Over six days, we observed 47 hours of working time for MO and 44 hours for PC. Both physicians spent 39 hours on clinical time, which they divide in an almost identical fashion. PC physician attended 40 patients and the MO physician 79 patients. The time spent with each patient was 20.4 min for PC and 11.6 min for MO. Time expenditure for PC was significantly longer for PC than MO: 'talking with team members' 11.8 vs. 4.8 min, 'talking with other physicians' 3.2 vs. 1.0, 'changing or prescribing medication' 2.9 vs. 0.9 and 'walking' or 'waiting' 7.5 vs. 1.5. PC dedicated almost three times as much to talking with nurses.
PC showed different clinical time expenditure per patient compared to MO, which might be described as more 'intensive' care because it results in longer periods of time devoted to a single patient and as a result, fewer patients were seen.

FC 10.6

Death and the team - How many patient deaths can they bear and how do they cope? A nationwide survey into palliative care units in Germany

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Aim: Working in palliative care (PC) means working in an environment where a non-normative frequency of experience with death and dying is a normative event of the everyday working life. It can be hypothesised that the particularly empathic accompaniment of patients adds to stress and the experience of loss. Research into this subject has been lacking. The aim of the study was to explore the number of patient deaths a team can bear, stress and coping factors.
Methods: Development of a standardised 11-item-questionaire (Q) (focus group); pre-test in 2006 (4 palliative care units (PCU). The Q was sent to all PCU in Germany (158); survey from 12/07-04/08, reminder. Descriptive and variance analysis, post hoc (Fisher's LSD) and Chi2 testing; significance level 0.05; principal components analysis, varimax rotation, 2-step cluster analysis.
Results: Response rate 60% (95 PCU); (n=873; nurses (N) 652, physicians (P) 99, social workers 20, physiotherapists 19, pastors 18, other 45, no entry 20); 78.6 female. Critical number of deaths/week 4.4±2.5. Consecutive deaths (00DDD00) were rated more stressful than evenly spread deaths (0D0D0D0). Greatest stress factor: not to have fulfilled the standards of PC (51.0%). Cluster analysis: 3 groups - severely (34.5%), moderately (37.9%) and not burdened (27.6%). Factors and composite measures: relationship

2.4, stress 2.1, responsibility 2.1. P were significantly more stressed by responsibility than others (F(5.730)=3.77; p=.002), women more than men by stress (F(1.763)=17,64; p<.001). Symptoms of a burdened team: loquacity (38%), irritability (28.6%), inter-professional tension (23.7%). P rated supervision ((F(5.833)=4.79; p=<.001) more helpful for coping than N; N mostly opted for distraction (F(5.841)=9.54; p=<.001) and humour (F(5.841)=4.78; p=<.001). The most important coping resource: the team (96%) itself.
Conclusion: This study gave first insights into an unexplored matter; a follow-up study in inpatient hospices is planned.

FC 11 Policy

FC 11.1

EAPC ESMO collaborative study of the the availability and accessability of opioids for cancer pain in Europe

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It is widely recognized that there are major problems with opioid availability and accessibility across Europe, and, as a consequence, many patients are suffering. In a collaborative effort national representatives of ESMO and EAPC were asked to report on the availability and accessibility of opioids in their countries using a structured questionnaire. The data was tabulated and cross correlated. When discrepant data was reported from the different national representatives of a single country efforts were made to clarify specific outstanding questions. Data from over 40 countries will be presented; this will include a detailed map of opioid availability across Europe. Major preliminary findings include:
1. Limitations in opioid supply to 14 days or less is very common in countries if the Former Soviet Union (FSU).
2. In many European countries physicians are not allowed to prescribe opioids on an "as needed" or PRN basis.
3. Some countries require that the physician acquire special permit or license for a patient to receive an opioid prescription.
4. Some countries require that physicians receive a special permit or license to prescribe opioids.
5. Most countries require that opioid prescriptions be written on special forms (Triplicate or duplicate) and in some countries accessibility to special prescription forms is difficult or limited and is a small number of countries the physician must purchase the forms.
6. In many states of the FSU opioids can only be dispensed at designated pharmacies that may be either in hospitals or special regional centers depending on local regulations.
7. Very few countries will allow telephone orders by a physician to a pharmacist in case of an emergency or correction of a technical error on a prescription by the pharmacists (at the physician direction).

FC 11.2

A ranking system for palliative care development in Europe: Proposals from an EAPC Task Force

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Background: In 2006 the Task Force produced the first EAPC Atlas of Palliative Care in Europe and began to work in more detail on the production of indicators of palliative care development that could be applied across national settings. In 2008 the Task Force collaborated on a project commissioned by the European Parliament concerned with the development of palliative care in the member states of the European Union.
Aim: To develop a ranking of palliative care development in the members states of the European Union.
Methods: The ranking uses two kinds of indicator:
1) volume of specific palliative care resources and services per million population
2) a measure of the 'vitality' of palliative care in a country, based on such factors as the existence of a national association, directory of services, physician accreditation, people attending congresses, publications on palliative care development.
Results: In the EAPC Ranking the United Kingdom attained the highest overall score. Countries with 85-50% of the UK score were (in descending order): Ireland, Sweden, Netherlands, Poland, France, Spain, Germany, Belgium, Luxemburg, Austria, Italy, Denmark, Finland and Latvia. Countries with 50-25% were (in descending order): Lithuania, Hungary, Bulgaria, Czech Republic, Slovenia, Cyprus, Romania, Malta, Greece, Portugal, Slovakia, Estonia.
Conclusions: This emergent approach to ranking has considerable potential. Key challenges are:
1) refining the quality of data used to compose the ranking
2) moving to an absolute, rather than a relative system of ranking.
This work is continuing in the Task Force.

FC 11.3

Implementation of graded palliative care within the public health care system in Austria - strategies and perspectives

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Aims: After intensive discussions between palliative care consultants and responsible politicians palliative care was integrated into the Austrian Health System in 2000. Further more the Ministry of Health and the Governors of the nine provinces in Austria have made it a priority to establish palliative and hospice care country-wide. In this study we tried to describe the development of a general plan for all parts of a graded palliative care system and how many services providing palliative care have been established in Austria.
Methods: 2004 members of the hospice and palliative care movement in Austria developed a concept for a graded palliative care system supported by "Gesundheit Österreich" (Austrian Health Institute). The main goal was to establish adequate palliative care for inpatients and outpatients all over Austria by 2012. The working group defined six different graded palliative care services and established guidelines for the number of services, staffing requirements, as well as size and structures for each.
Results: Since integrating palliative care within the National Health Plan, there are a growing number of new palliative care services all over Austria. By the end of 2007 228 services have been established: 24 palliative care units, 6 inpatient hospices, 2 day hospices, 30 hospital palliative care support teams, 31 home palliative care teams and 135 mobile volunteer hospice teams. However more hospital palliative care support teams, inpatient hospices and day hospices are still needed. In total approximately 440 services are needed in order to provide palliative care all over Austria.
Conclusion: Close co-operation between members of palliative care organizations and politics was necessary to integrate palliative care into the health system. After developing a nationwide plan and guidelines an increasing number pf palliative care services have been built up in Austria. Country-wide graded palliative care will most likely be available by 2012.

FC 11.4

Developing public health targets for palliative care in Germany: A Delphi study

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Aims: Improving palliative care is a public health priority, but so far it has been largely disregarded in Germany. Therefore, within a larger research project we perform a Delphi study in order to develop public health targets for better palliative care in Germany.
Methods: In the first project phase (04-08/2008) a standardized survey took place including 442 stakeholders from the meso and macro level of the German health care system (e.g. medical associations, nursing organizations, cost units, political institutions, patient organizations). The survey addressed three main topics: awareness of palliative care, hindering / facilitating factors, assessment of potential improvements. In addition, we performed a qualitative assessment of the views of international public health and palliative care experts with regard to similar topics. Based on the results, we develop a semi-standardised interview guide for a 2-stage Delphi study (timeframe 11/2008-03/2009). 15 outstanding national experts from the academic disciplines of public health and palliative care are recruited for participation. Using a quantitative and qualitative mixed methods design, the first round focuses on the question: What public health targets for palliative care arise from the survey findings? Data will be analyzed and summarized for the second Delphi round with the same participants. At this stage the focus will be on the relevance and priority of the identified targets.
Results: The methodical approach as well as the results from the first Delphi round and partial results from the second round will be presented at the EAPC-Congress.
Conclusion: For the first time in Germany, broadly based public health targets for palliative care will be developed. The results can be introduced into the currently initiated national Charta process concerning better care for seriously ill and dying patients.
Funding: The study is funded by the German Research Foundation (DFG).

FC 11.5

Integrated oncology and palliative care (IOP): The ESMO designated centers' experience and developments

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Aim: The application of palliative care principles and competencies to the whole trajectory of disease demands a high level of integration between oncology and palliative care. We will describe the ESMO experience with an incentive program which recognizes designated centers (DC) of integrated oncology and palliative care.
Methods: A cross-sectional semi-structured survey of all DCs (2.2008: n=27) was conducted about
1) the stimulation of service development (preparation of application, new services since ESMO DC),
2) the recognition (impact in daily work, business activity, funding of projects, national role and center identification), and
3) the appropriateness of the 13 criteria for DC to guide the integration process across various European cancer settings. A descriptive categorization and semiquantitative analysis was made.
Results: Of 27 centers, 24 responded (89%). 2 centers developed IOP before DC application, 19 developed various new services, in 12 the DC improved daily work (referrals, shared-care, continuity of care, peers' service recognition), in 11 the business activity, in 6 funding, and in 17 recognition. The survey revealed a need for both
1. more specific application criteria (assuring operationalisation of key palliative care principles and competencies) and
2. flexibility for regional and cultural differences of the integrative process (reaching from supportive care, to anticancer treatment in palliative intention to end-of-life and bereavement care).
The second generation of DC criteria will apply for 2009 DC applications.
Conclusion: The designated center incentive program has succeeded in stimulating program development of integrated oncology and palliative care. The ESMO DC process may serve as a model for incentive driven program improvement.

FC 11.6

Consultation time in Palliative Care: A preliminary study.

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Background: Consultation includes identification of patients needs, decision on their priority, and provision of care to meet the needs. Different studies have examined the consultation time and its determinants in various disciplines. In palliative care - a discipline with a distinctive interaction between health professionals, patients and families - the consultation process is time consuming; therefore it is essential to explore the relation between consultation time, its

determinants, its appropriateness and the quality of care.
Aim: To measure consultation times in different palliative care settings.
Methods: During a three week period, physicians of an academic palliative care unit (PCU) were request to measure the time they and the patient or their families were together in the room; interruptions were took away from consultation times. First time consultation (FTC), follow up visit (FUV), family advice (FA), and family interviews (FI) were measured in outpatient clinic (OPC), acute PCU (APCU), general ward (GW) and emergency room (ER).
Results: 278 consultation times were measured. In all settings, mean time in FTC (n=20) was 37 min. (8-80), in FUV (n=211) was 22 min. (3-115), in FA (n=4) was 43 min. (20-65) and in FI (n=43) was 27 min. (8-95). Differences: (a) for FTC, in OPC (n=8) 47 min. (13-80), in ER (n=6) 29 min. (16-40), and in GW, (n=6) 34 min. (8-55), and (b) for FUV, in OPC (n=63) 28 min. (3-115), in ER (n=4) 16 min. (8-25), in APCU (n=62) 21 min. (9-55) and in GW (n=82) 17 min. (4-50).
Conclusion: There were differences in the time spent with patients and families in consultations in diverse situations. This information is important to organize administrative and caring issues accordingly. This study is continuing to identify and compare the patients, teams and settings variables that determine the consultation length.

FC 12 Research Methodology

FC 12.1

Palliative care in first nations communities: A conceptual model to guide program development

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Aims: Aboriginal people are dying of illnesses where they could benefit from palliative care; however there is currently little research evidence to guide the development of palliative care programs within First Nations communities. This project begins to address these gaps in knowledge by implementing and evaluating a conceptual model for developing palliative care programs that is applicable nationally and internationally.
Methods: This program of research uses the Participatory Action Research (PAR) methodology. The conceptual model was applied and evaluated using data collected over four years in twelve First Nations communities located in Canada. The model includes four sequential phases: assessing and strengthening antecedent community conditions; creating a local catalyst for change, forming the local community team and growing the local program. PAR interventions used to implement the model were providing education, mentorship and facilitating collaborative practice.
Results: Case studies of twelve First Nations communities illustrate how the PAR methodology and the conceptual model can be applied to develop palliative care programs. As part of our research, four communities have the required antecedent community conditions to progress and are now being supported with PAR in phase two of the model: forming the local community team. Findings from the research have allowed the researchers to elaborate the conceptual model, in particular in the area of strengthening antecedent conditions.
Conclusions: Traditional urban approaches to palliative care are not appropriate to First Nations communities. This project aims to generate knowledge that supports innovative and context-specific approaches to developing palliative care. The four phase conceptual model for developing palliative care has proven applicable as a guide to developing programs in First Nations communities in Canada.

FC 12.2

Barriers to research in palliative care in Switzerland: A national survey

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Aim: Research in palliative care is often regarded as difficult due to certain peculiarities. To quantitatively assess Barriers to Palliative Care Research (B-PC-R) in Switzerland.
Methods: The questionnaire B-PC-R (EAPC 2006, #467) includes 5 main categories (ethical, financial and time resources, methodological, planning and conducting a study, politics) and 31 subcategories. It was sent (in the 3 swiss languages) anonymized to members of palliative-ch with 1 written reminder.
Results: Of 1681 B-PC-R 1003 (63%; 444, reminder 559) were returned: 188 physicians, 618 nurses, 176 other professions, and 21 not specified. 71% were women, 22% were <40 years and 9% >60 years. From the german speaking part were 61%, french 32%, and italian 7%. 160 (52 physicians, 71 nurses) were involved in the last 5 years in research, another 393 are interested. Key barriers were lack of time (35, 56), lack of money (18, 40), and of human ressources (8, 19). Professions differed about relevant patients´ burden of research (overall 51%, physicians 1/3, nurses and chaplains 2/3). 60% stated, that studies are helpful even in patients with limited prognosis. 85% reported insufficient ear-marked research time, 79% that research time is used by clinical demands, 27% had research budgets, 21% experience in grant writing, 83% stated, that qualitative research is more difficult to finance. Only 19% report a research environment with sufficient research expertise. 49% acknowledge perceived resistance of nurses towards research. 91% prioritize clinical work over research, and 70% own education.48% perceive english as foreign language as a research barrier (23% of physicians, 59% of nurses), 53% multilingual switzerland is a barrier (34%, 59%). 91% demand specific PC research institutes. 73% perceive variable PC definitions as barrier.
Conclusion: The representative survey data are consistent with other countries´ experiences and have also specific national PC research policy implications.

FC 12.3

A Delphi method for the development of a cancer pain guidelines - an EPCRC project

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To revise and develop new guidelines on the use of opioids for the management of cancer pain, we searched for existing guidelines and compared these with the current EAPC recommendations, to determine the optimum content of the new guidelines; 37 key-points were obtained. These key points were developed as statements and presented to a group of international experts using a modified Delphi method to gain consensus on the content of future guidelines. The experts were invited to give their assessment of the relevance of key-points; those that should and should not be included in the new guidelines.
Forty experts were invited to take part and twenty-eight agreed. Experts were asked to rank each of the 37 key point statements using an eleven point numerical rating scale, with the aim of creating collaborative guidelines. The questionnaire was sent to all experts via e-mail and free text space was allocated to encourage comments. Twenty-five experts completed the questionnaire. Prior to data analysis we developed cut off points for inclusion and exclusion of the statements before recirculation; a score of eight or greater was accepted, a score <6 was rejected and a score of six to eight was recirculated. 13 key point statements were accepted, six eliminated, and 18 with a score between six and eight were recirculated to experts with another questionnaire for the second round of Delphi. Experts were asked again to rank the statements, using the information from the previous round as feedback. Nineteen experts completed the second questionnaire and of the eighteen statements, four were accepted, one eliminated and 13 obtained an average score between six and eight. Experts maintained their previous score and only in a few cases the second score was different respect to the first one and close to the average. This process has enabled us to reach a consensus amongst experts for the content of new EAPC guidelines on the use of opioids in the management of cancer pain.

FC 12.4

Using two pairs of eyes: Applying simple visual techniques systematically and reliably to improve understanding of symptom changes over time

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Background: Symptoms in palliative care are often dynamic rather than static. But much prospective palliative research is cross-sectional and provides limited insight into change over time. The often small numbers in palliative studies also constrain use of formal longitudinal analysis techniques, such as multi-level modeling. These factors have limited our understanding of the evolution of symptoms over time.
Aim: To test and compare novel approaches to longitudinal analysis of repeated measures in the same individuals over time so as to contribute ways to overcome these constraints.
Methods: Using data from prospective longitudinal symptom surveys in advanced cancer, severe COPD, and end-stage chronic kidney disease (CKD), visual graphical analysis (VGA) was used to develop criteria by which to group individual trajectories of symptoms over time. These criteria were then applied by two different researchers, independently, and inter-rater agreement measured using Cohen´s kappa.
Results: Of 182 participants, 121 (66.5%) provided enough data (≥3 timepoints) to map their symptom trajectory (21 cancer, 43 COPD, & 57 CKD). VGA enabled these individual trajectories to be grouped into four categories: stable, fluctuating, increasing and decreasing. This approach was effective across the three diseases, and across different measurement scales (ratio, ordinal & continuous). Consistency of groupings was supported by high inter-rater agreement, with Cohen's kappa of 0.93 (CA & ratio scale), 0.85 (COPD & ratio scale) and 0.88 (CKD & continuous scale). In CKD, VGA was further compared with individual growth curve analysis techniques, achieving Cohen's kappa of 0.73 for inter-method agreement.
Conclusion: Visual graphical analysis is reliable and useful in longitudinal palliative care studies of relatively small size. Use of these techniques needs further development and wider application to better understand the crucial impact of changing symptoms for palliative patients.

FC 12.5

Serial qualitative interviews: An underutilised approach to understanding the evolving needs of palliative care patients and their carers

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Aim: Qualitative studies can yield an in-depth understanding of patients' and carers' experiences and needs, but, in palliative care, are mostly cross-sectional. We aimed to critique the strengths and limitations of using serial qualitative interviews to study patients with progressive illnesses, and their family and professional carers.
Methods: We reviewed our experiences of using serial in-depth interviews in six studies with patients with advanced malignant and non-malignant illnesses and their carers. We also gained international perspectives of the utility of this approach by drawing on interviews with experts in end-of-life research. We framed our experiences within a broader context by conducting a literature review using Medline, Embase, Cinhal and PsychInfo databases. Our findings are based on a thematic synthesis of these data and illustrated by quotations from our own studies.
Results: Longitudinal qualitative research offers considerable advantages in understanding the dynamic patient illness experience. Serial interviews allow an on-going relationship to develop, facilitating discussion of sensitive and personal issues, while also capturing changing needs and experiences throughout the illness. Moreover, parallel interviews with patient, family and professional carers (interview triads) can generate a rich, multi-perspective understanding of their various needs. Challenges to undertaking this approach include attrition, various ethical issues, timing of the first and subsequent interviews, developing appropriate handling and analytical techniquest, reflexivity and the time and costs incurred.
Conclusion: These challenges are surmountable and

with careful planning can be addressed. There is considerable scope for extending the use of this powerful technique of serial qualitative interviews in palliative care. Serial interview triads can be especially useful for planning improved services. We conclude by suggesting good practice guidelines.

FC 12.6

Interviewing older people about end of life issues: Engaging with ethical frameworks in four countries

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Background: There is an increasing emphasis on using qualitative research among older people to gain their perspectives on palliative and end of life care but little debate about the ethical issues involved. This paper has arisen from a European study focusing on the secondary analysis of interview data from older people about end of life issues in the Netherlands, Germany, Belgium and England.
Aims: The aim of this project was to develop understanding of the methodological requirements and constraints in studies of ageing and end of life care.
Methods: Ethical and research practice issues were identified during workshops focusing on interviews with older people (n=80) from six projects which had broadly similar concerns and which had been conducted in four countries. To facilitate this, the team compared transcripts and field notes. Where necessary these were translated. Summary 'pen portraits' about interviews were also compared.
Results: We noted across the four countries that the similar structures of the formal documents and procedures for ethical committee review did not correspond well with the purposes of our qualitative studies.
Across the four countries we encountered problems in gaining written informed consent from older people which are not adequately acknowledged in the literature. Examples of this included: the social significance of 'signing' consent forms; interpretations of project information; expectations about underlying motivations.
Researchers encountered ethical issues in the interview process with older people that were not embraced by the formal review procedure, for example, the role of supporting persons present in the interviews.
Conclusions: This paper makes recommendations to inform researchers who seek to engage with older people in palliative and end of life studies. We conclude that formal ethical frameworks should be complemented by attention to the development of understanding of practical ethical issues.

FC 13 Children

FC 13.1

A transition care pathway for young people with life-limiting conditions

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Aims: An estimated 6,000 to 10,000 young people live with a terminal illness or life-threatening condition, and many know that they will face a premature death during their teenage years. Their journey through adolescence into adulthood is compounded by facing a complex and often bewildering transition from children's palliative care to adult services. ACT: The Association for Children´s Palliative Care have developed this resource to guide and support young people, families and professionals through the transition maze and help services to better support young people to adjust to, prepare for, and move-on to adult services. It has been developed in response to the growing evidence of the unmet needs and growing numbers of young people living with a life-limiting condition into adult years.
Methods: The session will cover the need for developing the pathway approach, the involvement of grassroots experts in the development of the pathway and will consider the need for multi-agency working and consideration of end of life issues. It will also discuss the progress of the implementation phase of the pathway across the UK.
Results: The first phase of the implementation of the Pathway will be to undertake an audit of service provision, based on the five standards of the Care Pathway. Results of this audit will be discussed.
Conclusion: The Transition Care Pathway provides a flexible framework for enabling children´s and adult palliative care providers to work together to improve outcomes for young people with life-limiting conditions.

FC 13.2

Acupuncture to alleviate nausea and vomiting in pediatric cancer patients - A randomized multicenter crossover trial

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Background: We investigated whether acupuncture as a supportive antiemetic approach reduces the need for antiemetic rescue medication during highly emetogenic chemotherapy in pediatric oncology. We report about a multicenter crossover study at 5 tertiary hospitals in Germany.
Patients and methods: Ttwenty-three children (13.6 y, ± 2.9) receiving highly emetogenic chemotherapy for treatment of solid malignant tumors were included. Patients were randomly allocated to receive acupuncture treatment either during the second or third identical chemotherapy course together with standard antiemetic medication. The main outcome measure was the amount of additional antiemetic medication during chemotherapy. Secondary outcome measure was the number of episodes of vomiting per course.
Results: Fourty-six chemotherapy courses with or without acupuncture were compared. The need for rescue antiemetic medication was significantly lower in acupuncture courses compared to control courses (p=0.001) Episodes of vomiting per course were also significantly lower in courses with acupuncture (p=0.007). Except for pain from needling (4/23) no side effects occurred. Patients acceptance of acupuncture was high.
Conclusion: Individualised needle acupuncture as applied in our trial seems to be a cheap and effective method for reducing both, the amount of antiemetic rescue medication and the incidence of retching and vomiting in children and adolescents during highly emetogenic chemotherapy.

FC 13.3

Developing children´s palliative care in South Africa through developing local resource centres in all provices

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South Africa has the highest number of people living with HIV and AIDS. Whilst hospice services for adults are well-developed and effective, children receive few services. Children under 4 years have the highest mortality rate due to infections such as TB and pneumonia, and malnutirition. In 2007 there were only 6 children´s hospice palliative care resources. Through donor funding, the Hospice Palliative Care Association of South Africa designed a model to identify 18 sites that could be developed through training and support, to provide palliative care to children, with at least one centre in each of the 9 provinces of South Africa. Training materials, policies and children´s palliative care documents were developed, as well as a Toolkit for Developing Children´s Palliative Care in Africa. Members of the Hospice Palliative Care Association of South africa contributed to the first Textbook on Children´s Palliative Care in Africa, relevant to the resounces available in the developing world and relevant to the different cultures. The 18 hospice sites received training, support and supervision, with a qualitative and quantitative assessment carried out at each site. The number of children in palliative care programmes increased from 3 200 at the beginning of the year to 7 000 by September 2008. Assessment of records and progress reports showed an improvement in assessment of children, including developmental and pain assessment,treatment of psycho-social problems and pain management in children. The assessment showed the need for ongoing training and support of sites. In September 2008 a further 22 sites were identified for the roll-out of children´s palliative care with 3 sites identified for development as Centres of Excellence in children´s palliative care. These sites will be developed to provide clinical experience for multi-disciplinary professionals from countries in sub-Saharan Africa linked to training with a piloted curriculum.

FC 13.4

Home death for children dying in six European countries

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Aim: Guidelines on pediatric palliative care underline that care at the end of life of chronically ill children should preferably be provided in the child's home situation. Till present, no European data at population level are available for place of death of children. The aim of this study was to compare proportions of home death for children in six European countries and investigate relation between place of death and sociodemographic and clinical factors.
Method: Data were collected from death certificates of all deceased children aged 1-17 in Belgium (BE), the Netherlands (NL), Norway (NO), England (E), Wales (W) (2003) and Italy (IT) (2002). Gender, cause (cancer, natural non-cancer and external) and place of death (home vs. outside home) and sociodemographic factors (socio-economic status (SES), degree of urbanization and number of hospital beds in the area) were included in the analyses. Data were analyzed using frequencies and multivariate logistic regression.
Results: A total of 3.187 deaths were included in the analyses, 534 (16,8%) died from cancer. The proportion of home deaths was 19,6% (IT), 20,5% (E), 20,6% (W), 21,0% (NO), 23,8% (BE) and 28,6% (NL). Home death was more likely for children dying from cancer in BE, NL, E and W, for children with high SES in BE, in areas with low number of hospital beds in IT, and for boys in NL.
Conclusion: The proportion of home deaths for children differs between studied countries. In most, but not all, countries children dying from cancer had better odds of dying at home than those not dying from cancer. Although acknowledging the influence of culture in the differences, studying care provisions in countries with higher proportions of home deaths, particularly in chronically ill children, can be helpful to identify factors facilitating terminally ill children to die at home. Early involvement of palliative care and equal access to these services can be important in this context.
Funding: IWT-Flanders.

FC 13.5

Interdisciplinary palliative care for children with congenital heart defects and other severe heart conditions

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Background: Despite major advances in pediatric cardiology and pediatric cardiac surgery during the last two decades, the life-expectancy of some patients remains shortened, e.g. children with hypoplastic left heart syndrome. Children and adolescents with complex congenital heart defects and other heart diseases have a need for highly qualified pediatric palliative care as well as cardiologic care.
Patients: From 2004 to 2008 the Coordination Center for Pediatric Palliative Care (CPPC) cared for 23 patients with complex congenital heart defects and other severe heart diseases (average age 4 yrs, range 0-18 yrs). In 15 cases pediatric cardiologists involved the CPPC-team during the decision-making process. In 5 cases life-prolonging measures such as extracorporeal membrane oxygenation were discontinued after the consultation. In 9 cases the CPPC coordinated the care at home; in 4 cases a consultation regarding goals of care preceded discharge from hospital. Altogether, 15 patients died, 7 of which at home. Four children suffered from complex congenital dysplasia syndromes. One child was diagnosed prenatally and the parents decided to continue the pregnancy after contact with the CPPC. The average follow-up time at home by the CPPC until death was 5.6 months (range 0.7-12 mo). Selected case reports describe the special challenges of palliative care for pediatric cardiologic patients.
Conclusion: Interdisciplinary cooperation between pediatric cardiologic and pediatric palliative care teams may be helpful in decision-making concerning goals of care. Home care for children with incurable heart disease is more effective when care is coordinated by a pediatric palliative care team which is available for consultation by patients, parents, doctors and nurses. Such a team can address disease-specific aspects of care and assist in advance care planning, e.g. by establishing an emergency plan. This can stabilize the care situation and makes end-of-life care at home more likely.

FC 13.6

Absorbing information about a child´s incurable cancer prognosis: Perspectives of bereaved parents

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Aims: To assess parents' ability to absorb information that their child's illness was incurable and to identify factors associated with parents' ability to absorb the information.
Study design and methods: An anonymous mail-in questionnaire study was performed as a population-based investigation in Sweden between August and October of 2001. 449 parents who lost a child to cancer 4 to 9 years earlier (response rate 80%) completed the survey. 191 (43%) of the bereaved parents were fathers and 251 (56%) were mothers. For outcomes of interest, we report relative risk (RR) with 95 percent confidence intervals (CI). To assess relative importance, a logistic regression was performed.
Results: Sixty percent of parents (N=258) reported that they were able to absorb the information that their child´s illness was incurable. Parents were better able to absorb the information that their child's illness was incurable when the information was given in an appropriate manner (RR 1.6; CI 1.3-2.0), when they shared their problems with others during the child´s illness (RR 1.4; CI 1.1-1.8) and when they had no history of depression (RR 1.3; CI 1.0-1.8). When mothers were able to absorb the information, they were more likely to have said farewell to their child in the way that they wanted to (RR 1.5; CI 1.3-1.9). Children of fathers who reported having absorbed this information were less likely to have died at home (RR 1.5; CI 1.0-2.2).
Conclusions: Parents who received information that their child's illness is incurable in an appropriate manner are more likely to absorb that information. Whether or not parents are able to absorb the information that their child's illness is incurable has implications in terms of location of death and preparation for the child's impending death.

FC 14 Non-Cancer

FC 14.1

A randomized controlled trial of palliative care consultation on hospitalized patients with advanced heart failure

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Aims: Although Heart Failure (HF) has accelerated functional decline, multiple co-morbidities and high mortality, few patients are referred to hospice care after acute hospitalizations, perhaps because of poor access to palliative care. We designed a randomized controlled trial to test the hypothesis that a palliative care consult (PCC) intervention would lead to an increased utilization in hospice/palliative care.
Design: Prospective randomized controlled trial of patients hospitalized with advanced (New York Heart III/IV or >30% predicted 1 year mortality) received either PCC or standard disease management. Patients were excluded patients if they had other terminal disease/malignancy, cognitive deficits/psychosis, or were heart transplant candidates. Primary outcome variable was the utilization of a palliative approach of hospice or DNR+comfort care.
Results: Patients were predominantly (90%) black and 53% male. The intervention and control groups respectively (n= 42 per group) had comparable ages of 66.5 vs 68.0 years (p=.57) and Lee heart failure severity scores (109 vs. 107), and McGill quality of life scores (p=.9) at baseline. At 3 month follow-up, 14/84 (16.6%) of patients had died. A total of 4/42 (9.5%) met the primary outcome in the intervention group and 0% in the control group (Fisher´s Exact test 2-sided p=0.11).
Conclusion: Palliative care consultation had a modest effect on the primary outcome, and the effect size approached but did not achieve statistical significance. In this mostly African American population, barriers to palliative care included patient/family mistrust of the health care system, a reluctance to plan for incapacitating illness, and a fear that comfort care might lead to minimal care. Tailoring of a palliative care intervention to address these barriers might result in increased comfort and knowledge for patients with exacerbations of advanced heart failure.

FC 14.2

Discussing prognosis in advanced COPD: Findings from a qualitative study with medical and nursing staff in the UK

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Background: Prognosis in COPD is poor and many patients perceive shortcomings in the education they receive about aspects of their condition, including prognosis. This paper addresses the views of health care professionals regarding discussing prognosis with patients with COPD.
Method: 44 medical and nursing staff involved in the care of patients with COPD in primary and secondary care settings participated in five focus groups.
Results: Findings revealed that participants were aware that they managed discussions relating to prognosis badly. There was reluctance amongst participants to initiate such discussions, with several key barriers cited. These included limited time in consultations, lack of training in delivering bad news, and not wanting to 'depress' patients. Difficulties were identified with recognizing the appropriate time to initiate discussions because of the uncertain illness trajectory of COPD. Some participants reported an unwillingness to initiate discussions unless the patient had specifically requested the information. Avoidance was identified in some participants who variously reported patients to be too old, too young, too sick, or too healthy to discuss prognosis. Aids to discussing prognosis were identified. These included the presence of a family member or carer, initiation of discussions by the patient themselves, having a good relationship with the patient, and discussing smoking cessation as a prompt to a discussion of prognosis.
Conclusion: Although the majority of participants agreed that they discussed prognosis badly, participants had differing opinions regarding if and when discussions should be initiated. Despite the poor prognosis associated with COPD and the shortcomings in education perceived by patients, open communication regarding prognosis is not routine in either primary or secondary care.

FC 14.3

Challenging gender stereotypes in palliative care

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Aim: Given the devastating effects of HIV/AIDS on the lives of women in South Africa, particularly young women disproportionately vulnerable to infection and girls and older women who bear the burden of care in the home, the Hospice Palliative Care Association (HPCA) identified the need to explore the influence of gender perceptions on care delivery within its member hospices. The aims were to promote increased gender awareness, to incorporate gender sensitivity in patient/family care and to develop gender guidelines.
Method: Hospices completed two questionnaires focusing on key gender issues at an internal organizational level and at the programme/service delivery level. Responses indicated that hospice staff were, on the whole, unclear on what was meant by gender and how it played out in both the internal and external workings of the organiation. Regional gender workshops, facilitated by contracted gender consultants, offered hospice staff the opportunity to explore such diverse issues as gender stereotypes, the empowerment of women as patients and carers, the involvement of males, stigma and the need to include gender criteria in policies and standards.
Results: Gender guidelines drafted with input from workshop participants, will provide a resource to promote gender sensitivity in all aspects of palliative care programmes. A national HPCA Gender Task Team has been established to take into account the gender dimensions of palliative care within portfolios ranging from patient care, education and research to advocacy and organisational development.
Conclusion: Gender needs to be seen as an inextricable part of the provision of palliative care, particularly with regard to HIV/AIDS. We believe that this ground-breaking work can make a significant contribution to enhancing patient care and family support by taking gender roles and gender needs into account.

FC 14.4

'Total carers', or wives caring for husbands with a long-term illness

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Background: Recent trends in UK health policy have shifted increasingly from institutional to community care. Reconfiguration of services need to develop support programmes for informal carers who provide most of the care for patients with a long-term illness.
Aim: To examine the role expectations of wife carers for husbands with a progressive and life-limiting illness.
Methods: A purposive sample of 15 wife carers was selected. They were recruited via their husbands who suffered from a long-term illness (COPD, cancer, MND, heart failure), from outpatient clinics in the hospital, and from a palliative care team providing home care.

Data were collected through semi-structured, in-depth interviews. All were tape-recorded and transcribed verbatim. This was complemented by participant observation during outpatient consultations. The analysis followed the initial stages of Grounded Theory and used Discourse analysis. NVivo software was used to manage and assist the analysis of the data.
Results: Descriptions of tasks, and the values attached to these, revealed that wife carers aspired to provide all the care by themselves. Interference from outside was seen as failure. They saw their role as a duty, which could be traced back to existing feminine responsibilities to take care, love and nurture the sick and vulnerable. These ideas are reinforced by self-health discourses placing responsibility for health with the individual. This leaves wife carers with huge caring burdens, which are usually taken for granted.
Conclusion: To support carers in their role they need
1. A complete system of available professional expertise and care,
2. training in nursing skills, and education about their role in the care system,
3. interactive support, recognising wives as the providers of 'total care'.

FC 14.5

Navigating a palliative approach in residential aged care: Reflecting on the key outcomes from the Residential-Palliative Approach Competency (R-PAC) project and the importance of collaborative partnerships

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Aim: The R-PAC Project aimed to collaboratively develop, implement and evaluate a sustainable model of care to facilitate the delivery of a palliative approach for older people admitted to nine residential aged care facilities (RACF) in regional Australian.
Methods: Action research underpinned the R-PAC Project with eight distinct but interrelated studies guiding this process. These studies included: a focused needs assessment (Study A), pre and post test chart audits (Studies B & F), focus groups with aged care providers (Studies C & G) and general practitioners (Study E) and a pre and post test provider survey (Studies D & H).
Results: Action research facilitated a cascade of engagement with all RACF. The data provided valuable insights into usual practice, collaboratively engaging aged care nurses, care assistants and general practitioners in developing practical solutions to enhance palliative care delivery in this setting and guided the development of a multifaceted intervention. Key outcomes from this research are the need to acknowledge and validate the role of aged care providers, the value of personal empowerment and the importance of multidisciplinary collaboration. There is a need to further embed the use of validated assessment tools, to promote advance care planning, support the creation of multidisciplinary teams and develop sustainable strategies to maintain links with specialist pallaitive care services.
Conclusion: The R-PAC Project has provided greater insight into the palliative care needs of older people in residential aged care and has foster the collaboratively development of a model of care that promotes the delivery of a palliative approach.

Poster sessions (Friday)

PE 1.F1

Developing a measure for excess respiratory secretions or 'rattle' at the end of life

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Excess respiratory secretions or rattle is a commonly occurring symptom at the end of life. Centralised variance monitoring from the Integrated Care Pathway (ICP) for the last days of life has resulted in a database of over 10,000 entries from various care settings across Wales.
Analysis of this database shows that despite the use of the recommended anti-cholinergic medications and nursing interventions rattle continues to be problematic for 33% of a sample of 10126 patients. Fully powered trials seeking to determine the most effective medication/management of this difficult symptom will need an outcome measure.
In concurrence with the recent Cochrane review our literature review failed to identify any studies using an existing outcome measure for rattle. Consequently a UK expert medical, nursing and academic panel was convened to agree a measurement scale for rattle that could be used as part of routine care. The panel agreed on two visual analogue scales with simple positive/negative anchors to assess the volume and the wetness of the rattle.
In the absences of any 'gold standard' against which to validate the proposed new scale, internal, external, construct and face validity need to be established along with reliability.
The scale has been used satisfactorily in a small sample of patients. Colleagues report that it is simple to use and easily incorporated into routine observations and is therefore unobtrusive to the patient or their carers. Further use with a larger sample of patients in different care settings is required to establish full validity and initiate tests of reliability.

PE 1.F2

Depression among patients with advanced disease; Do standardised screening tools improve identification?

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Aim: To explore whether the introduction of a standardised screening tool represents a more effective method of identifying depression among patients with advanced disease. The screening tool was compared to existing non-standardised patient assessments-conversations with health care professionals working in the hospital palliative care setting.
Methods: The study involved three stages. Stage 1 was a retrospective review of palliative care notes.Observational techniques were used to identify the proportion of patients with a documented diagnosis of depression, explore their characteristics and calculate the prevalence of depression. Stages 2 and 3 were prospective, recruiting newly referred patients to the palliative care team. In stage 2 the patients were assessed in the routine clinical manner. In stage three, the same group of patients completed the Hospital Anxiety and Depression Scale (HADS). Results from stages 2 and 3 were compared in terms of prevalence of depression diagnosed and level of agreement between the two methods. Comparisons were also made between the characteristics of and treatment plans implemented for those with a diagnosis of depression.
Results: Stage 1 (n=74), 62% had a psychological assessment documented. The prevalence of depression was 22%. Depression was more common in people living alone and in those with cancer of the lower gastro-intestinal tract. Stages 2 and 3 (n= 30), 70% had a psychological assessment documented. The prevalence of depression in stage 2 was 24% compared with 48% in stage 3. Comparing the two methods, there was agreement in 57%. The Cohen-kappa statistical test for agreement was 0.12 (poor agreement).
Conclusion: The HADS is a useful method of screening for depression and identifies more patients than routine clinical assessment. However this does not equate with being more effective in clinical practice.Routine use of the HADS may prompt professionals and increase their confidence in psychological assessments.

PE 1.F3

"A risky risk assessment?!" Is risk assessment for venous thrombo-embolism appropriate for palliative care inpatients?

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Background: Risks of venous thrombo-embolism (VTE) and clotting disorders are high in the palliative care population due to cancer, advanced disease, poor mobility and age. The UK government have recently released a VTE risk assessment tool to be used for all patients on admission to hospital (surgical/medical/obstetric).
Method: 50 consecutive in-patient deaths, within a 5 month period, in a specialist palliative care unit were identified. The VTE risk assessment tool was retrospectively applied. Concurrently the incidence/occurrence of symptomatic VTE and time to death in this group of patients was documented.
Results: The results show the implications of applying this tool in this population and the questions raised about the appropriateness of following the national guidelines for thrombo-prophylaxis in this patient population.

PE 1.F4

Get SMART - Objective setting on hospice admission

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Aim: To investigate whether it is possible set SMART (Specific, Measurable, Achievable, Realistic, Timely) objectives and measure outcomes for patients admitted to the inpatient unit (IPU) at St Barnabas Hospice. At St Barnabas, setting of objectives prior to admission is an important part of the preparation for the patient and family members. It also guides the medical and nursing teams in tailoring an individual care plan over the course of the stay. To focus the direction and clarity of these goals, this study aims to assess whether the business acronym SMART can be applied to clinical objective setting.
Methods: This is a prospective survey of new admissions to the IPU between 21/04/08 and 23/05/08. As part of routine medical clerking, the admitting doctor agreed objectives for admission with the patient, aiming to fulfil SMART criteria. Outcomes were followed up over the course of the admission at the twice weekly Consultant ward round or a critical change in the patient pathway. The end point for assessment and review of outcomes was the point of death or discharge.
Results: Thirty four patients were assessed and objectives set with 25 (74%). A total of 44 objectives were set and 22-29 (55-66%) were considered SMART by two reviewers. On assessing outcomes, 31 (70%) of initial objectives were achieved.
Conclusions: We have shown that it is possible to set SMART objectives with patients on admission to the IPU and to follow these through to their conclusions. We would recommend setting clear goals which are realistic and achievable for the individual patient. Employing the concept of SMART objective setting may also help facilitate discussions with some patients to help them explore insight and prognosis.

PE 1.F5

How to assess remaining life-span

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Aims: In palliative care it is always essential to plan for the future. What problems can be expected? In what setting shall the care be provided? In the palliative care team the different members get different views of the patient and the current situation. In this study the different team professions ability to assess expected place and time of death is demonstrated.
Methods: A consecutive number of patient recruited from a in-patient palliative care unit were assesed on day 3 after admission. All teammembers involved filled in a form with their assessement of life expectancy and expected place of death. These data, along with diagnosis, age, sex and marrital status, were after the study period compared with actual place and time of death.
Results: As demonstrated in earlier studies nurses and assistant nurses make prognosis more accurate than physicians. Personel with long working experience make better prognosis than unexperienced. In some cases the assessements are far from accurate, especially in cases with long life expectancy. Relationships with diagnosis, age, sex, marrital status and place of death are demonstrated in the poster.
Conclusions: In order to provide good palliative care it is essential to discuss prognosis as well as expected place of death in the multiprofessional palliative care team. Personell involved in nursing and in close body contact with the patient, seems to be better at assessing, and need to be closely involved in the discussions about prognosis.

PE 1.F6

Descriptive study of the complexity case-mix visited by a palliative home-care team. 2 years follow-up study

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Aims: To study characteristics and complexity factors of home-care palliative oncology patients and analyze their relationship with the place of death.
Design: Prospective cohort study.
Setting: Primary care, Urban and rural areas.
Patients: New palliative oncology patients followed for 24 months from 01/01/2006 to 31/12/2007. N=208, 22 excluded.
Measurements: Age, Sex, Living area: Urban/Rural, Cancer type, Barthel, Karnofsky. Complexity: Clinical, Ethics, Assistance, Social.
Place of death: Home/hospital.
Results: Men:119(64%), Women:67(36%), Living area: Rural 52(28%), Urban 134(72%). Mean age 71,8. Place of death: 48% Home, 52% in Hospital /Hospice. Bivariant analysis: There where no diferences in the place of death with regard to sex or living area of the patients. Patients dying at home were older (mean age 74,5 years) than those who died in hospital (69,35 years), statistic significance (p=0,0016).
Almost all patients (93,5%) had at least one complexity factor.(Mean number complexity factors:3,03). The relative frequencies of complexity factors were: Clinical 60%, Social 22%, Asistance 14%, Ethics 4%. No relationship was found between number of complexity factors an place of death. The mean Social Complexity is higher (0,82) in patients dying in hospital or hospice than in those dying at home 0,49 (p=0,0091). The multivariate analysis confirmed the association of age and Social Complexity with the place of death.
Conclusions: Home-care palliative patients studied had a preponderance of male sex (64%), with a mean age of 71,3 years and 93,5% had at least one compleity factor (mean of 3,03). Age and Social complexity factors were statistically associated with place of death. In our cohort Clinical complexity is not associated with place of death. Future studies focused on analysis of complexity factors in different geographic areas would be of great interest.

PE 1.F7

Systematic symptom monitoring in a hospice

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Aim of the study: To assess the use of systematic symptom monitoring for screening and evaluation of the effect of symptom management in a hospice.
Design and methods: A modified Edmonton Symptom Assessment Scale (using a numeric rating scale of 0-10 and a cut-off of 5) for 13 symptoms was used in hospice patients at admission and subsequently at least twice a week. Symptoms are reported as median scores, percentage of patients with a symptom score of >4 and the percentage of these patients showing an improvement of at least 2 points after 1 week.
Results: 47 patients (45% male, median age 74 years, 87% with cancer) were admitted between July 2007 and August 2008. Survival: 28% 1-7 days, 44% 8-30 days, 28% >30 days. Symptom monitoring was possible in 81% of patients for a median period of 2 weeks. Patients discontinued symptom registration because of deterioration (62%) or not being able (23%) or being

unwilling (15%) to score their symptoms.
Pain: median score at admission 2.43, number of patients with a symptom score >5 at admission 26% (33% of these patients showing an improvement after 1 wk); nausea 0.91, 11% (50%); depression 1.63, 17% (32%); anxiety 0.84, 7% (0%); drowsiness 2.09, 23% (25%); anorexia 4.97, 65% (25%); dyspnoea 2.20, 23% (37%); insomnia 1.97, 21% (57%); fatigue 6.66, 87% (36%); constipation 1.83, 20% (50%); confusion 1.12, 12% (25%); dry mouth 4.66, 56% (39%); dyphagia 2.21, 30% (30%).
Conclusion: Systematic symptom monitoring is feasible in the majority of a sample of 47 hospice patients. Fatigue, anorexia and dry mouth show the highest scores at admission. Improvement after 1 week is seen in 25-57% of patients with high initial scores.

PE 1.F8

Barometer to measure stress levels among care staff

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Aim: To adequately measure stress in hospice caregivers, so that appropriate interventions can be planned and carried out. Caregiver burnout has serious consequences for the caregiver, care recipient and health care system. Caregivers struggling with emotional exhaustion often become less sensitive to the care recipients feelings and needs. This increases the likelihood that the care recipient will be treated in a mechanical fashion.
Methods: An assessment tool was developed to regularly measure stress levels among Professional Nurses and trained caregivers. Six key stress related variables are monitored on a monthly basis and the results from the coping levels measure are displayed on a monthly basis and the results from the coping levels measure are displayed on a bar graph.
Results: This tool enables the supervisor to target specific areas that the care staff appear to struggle with and plan meaningful intervention. Over time, the results from the monthly assessments indicate which interventions have indeed had a positive influence on the manner in which the staff have coped with stress, as well as trends in stressors.
Conclusion: This useful tool has been applied with good results, and has been shared with other hospices in the South African context.

PE 1.F9

Experiences by implementing ESAS in an hospice day care unit

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Aim: To be able to give optimal symptom palliation. Make the staff aware of the patient`s general health picture. Allow the patients to express their own experience in a simple way. Gives a starting point for eventual intervention and consequent follow-up. Hospice day centre gives patients with an advanced and incurable disease, the chance to meet others in the same situation socially. The multidisciplinary team have the common goal of offering the patient palliative treatment, and helping them with other problematic themes. Priority is given to a wide range of activities at the Hospice, in the belief that both taking part and achievement is very beneficial to the patient`s general feeling of well-being. The patients, and their nearest kin, are treated otherwise as unique individuals.
Methods: The patient fills out the ESAS questionnaire each time they come. The scores are later filled in, in the patients file. There, the patient`s prime contact can observe and compare the different scores, and take the appropriate initiatives, if needed.
In a two week period, the patients where asked to fill out the ESAS form both on arrivial, and on leaving. The results showed that symptoms that were troublesome in the morning, had become less troublesome during the course of their stay at the Hospice!
Results: We experience ESAS as a meaningful clinical tool. It helps us to keep in focus important symptoms, subsequent following up of these, and is a basis for working together with the patient. The complexity of the patient`s experiences of pain and discomfort means that each patient needs to be understood and met as an individual. ESAS visualises their sufferings and help predict and more understanding for coherence and that the patient and health worker plan together.
Conclusion: "You haven`t given me any tablets, but even so I feel in a much lighter mood now. I don`t know what you do - but it works!"

PE 1.F10

Prognosis accuracy of PPI and PaP Score in terminally ill cancer patients: Which one is better?

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Objective: To compare the prognosis accuracy between the PPI (Palliative Prognostic Index) and the PaP Score (Palliative Prognostic Score), in predicting the survival of terminally ill cancer patients attended by a Home Care Support Team.
Methods: Observational, prospective study. All the terminally-ill cancer patients (n=17) attended to between 1st April and 31st September 2008 were included in the study. We collected the following variables: age, sex, tumor localization, variables that integrate the PPI (Palliative Performance Status, state of oral intake, dyspnea at rest, edema and delirium), variables that integrate the PaP Score (dyspnea, anorexia, Karnofsky Performance Status, total white blood count (WBC), Lymphocyte Percentage and Clinical Prediction of Survival); and survival time defined as the number of days that passed between the initial visit and the date of death.
Results: During the study period, 17 patients died and were included in the analysis. 52.9% of the studied subjects were males. The mean age was 75.3. The three most common localization of primary tumor were the gastrointestinal tract (52%), genitourinary tract (12%) and liver (12%). The median of survival was 14 days. PPI over 4 predicted in our patients a survival below 6 weeks with a 31% sensitivity and a 100% specificity. No patients had PPI over 6, so threshold at 6 could not be evaluated. Survival over 30 days was 75% in patients with PaP Score below 5.5, and 22% in those with PaP Score between 5.6 and 11. No patients with PaP Score over 11 survived.
Conclusions: The PaP Score had a better accuracy in predicting survival time in our patients but a larger sample size is needed in order to draw stronger conclusions.
Keywords: Palliative Prognostic Index, palliative care, PaP Score, predictors of survival, advanced cancer.

PE 1.F11

Assessment of palliative care needs of patients with Chronic Liver Disease at a rural tertiary referral centre in Pakistan

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Background: Hepatocellular Carcinoma (HCC) and Chronic Liver Disease (CLD) are relatively common in our region (rural Pakistan) because of high prevalence of hepatitis viral infection B and C with significant palliative care needs. However there is lack of data on such needs of patients with CLD.
Aims: To determine the physical Palliative care needs of patients with HCC and CLD that require medical admissions in last three months of life.
Patients and methods: Prospective study of 40 consecutively admitted patients with CLD and HCC in our liver ward over a 4 months period who died within 3 months of data collection.
Results: There were 32 males and 8 females with an average age of 58.5 years (range=45-70). All had Ultrasound scan findings suggestive of HCC and CLD with raised levels of Alfa-fetoprotein in 32 patients. 4 patients had a positive serology for hepatitis B s Antigen, 3 had a history of heavy alcohol intake, 7 had no known risk factor for liver disease and the remaining 26 patients had serology positive for hepatitis virus C. On presentation, 36 patients (90%) complained of abdominal pain/discomfort, 24 (60%) weakness, 14 (35%) bodyache/pain, 11 (30%) had low grade fever, 3 each (10%) had leg pain and upper GI bleed and 2 patient (5%) complained of severe weight loss. 10 patients (25%) also had ascites accompanied by abdominal pain/discomfort.
Conclusion: Abdominal pain/discomfort are the commonest reasons for admission in our patient population suffering from HCC and CLD. Asthenia/weakness (60%) and bodyache/pain (35%) are the second and third commonest presenting features.
Discussion: Patients with incurable Liver diseases need Palliative care in line with World Health Organisation definition. There is growing data on patients with non-malignant diseases and their Palliative care needs. However, there is less data on Liver disease. Large scale studies are needed to determine psychological, social and spiritual needs of these patients.

PE 1.F12

Prognostication in the hospice setting: The usefulness of the modified Glasgow Prognostic Score

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Aim: Cancer patients and their families frequently request information on prognosis. Inflammation appears to be an important factor in assessing prognosis in cancer. The recently modified Glasgow Prognostic Score (mGPS) - which combines thresholds of C-reactive protein (CRP) and albumin - is an independent predictor of survival in cancer patients, but has never been used to assess patients in a specialist palliative care unit (hospice). The aim of the study was to establish whether the mGPS predicts survival in hospice inpatients with advanced cancer.
Methods: A retrospective note survey was carried out. Patients who had both CRP and albumin measured during the admission were included. mGPS was calculated as follows: patients with elevated CRP (> 10mg/l) and low albumin (< 35g/l) were scored mGPS 2. Those patients with a raised CRP alone were scored mGPS 1. Those with a low albumin alone, or if both parameters were normal, were scored mGPS 0. Survival analysis was performed using the Kaplan-Meier method with the log-rank test.
Results: Data was obtained for 97 patients. Thirteen patients had mGPS 0, 18 patients mGPS 1 and 66 patients mGPS 2. Median survival from date of blood test for the 3 groups was 47 (5-400) days, 47 (1-216) days and 23 (2-252) days respectively (p=0.016). When a survival cut-off of 2 weeks was used, comparing mGPS scores of <2 and 2, sensitivity was 87.5%, specificity was 41.5%, positive predictive value was 42.4% and negative predictive value was 87%.
Conclusion: The mGPS is predictive of survival in hospice patients with advanced cancer. However, the majority of patients with mGPS 2 survive longer than 2 weeks. Nevertheless, the high negative predictive value suggests that patients with mGPS < 2 are very likely to live more than 2 weeks: this has implications for assessing the most appropriate place of care for this group. The study did not require funding and was carried out as a medical student project.

PE 1.F13

Assessing prognosis in the hospice: The views of nursing staff

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Aim: Patients and families frequently ask hospice staff how long the patient will survive. Some prognostic scales using blood tests may provide information which will guide answers to this question. Little is known of the views of hospice staff on these issues. The aim of the study was to establish the views of hospice nursing staff on how they assess prognosis, on the importance of giving prognostic information and their views on a prognostic test involving blood sampling.
Methods: Six short semi-structured interviews were carried out with staff nurses working in a specialist palliative care unit (hospice). The interviews were recorded and transcribed verbatim. The transcripts were analysed thematically.
Results: Themes identified:
1. Diagnosing dying: as patients became less well, they experienced more physical symptoms and became more dependent on nursing staff.
2. Changing priorities: patients experienced shrinking of their horizons and focussed on tying up loose ends.
3. The Nurse's Response: nurses altered their care approach, with an emphasis on comfort care and filling gaps between patient's abilities and what needed done.
4. Assessing prognosis: some nurses discussed use of intuition, based on clinical observation and building a relationship with the patient. Half felt that a scoring system based on blood tests might be helpful if it was

minimally invasive.
5. "How long?": it was important to answer the question honestly, but emphasise the imprecision of prognostic estimates; family could find uncertainty difficult.
Conclusion: Staff played an important role in assessing prognosis and in facilitating increasing need for care and managing unfinished business. The use of a prognostic test was not excluded, but some preferred to rely on intuition and clinical experience. Prognostic questions were answered honestly, although families were left with some uncertainty. The study did not require funding and was carried out as a medical student project.

PE 1.F14

Which symptoms and problems do patients in palliative care report in addition to those included in the EORTC QLQ-C15-PAL? Presentation of a brief instrument supplementing the EORTC QLQ-C15-PAL

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Aim: The EORTC QLQ-C15-PAL questionnaire measures nine symptoms and problems (S/P) frequently reported by patients in palliative care, as well as overall quality of life. This study aims at
(1) presenting a brief supplementary instrument asking patients to report up to three additional S/P, and
(2) investigating the nature and frequency of S/P reported using this new instrument.
Methods: The supplementary instrument was used in a department of palliative medicine in patients who had just completed the QLQ-C15-PAL. It asks the patient to list up to three S/P, that are not included in the QLQ-C15-PAL. The results were analyzed qualitatively (by coding) and quantitatively (frequencies in each category). The qualitative analysis used the following steps:
(1) If the response concerned an S/P already included in the QLQ-C15-PAL (e.g. ´pain in the foot´) it was coded using a category indicating this (e.g. pain).
(2) If the response concerned an S/P NOT included in the QLQ-C15-PAL a coding system for ´additional S/P´ was used, employing either 48 existing symptom categories (Homsi J, Walsh D et al. , SCC 2006) or additional S/P categories developed within this study.
Results: Among 373 patients, 191 patients (51%) reported at least one additional S/P; 315 in total. These 315 responses were coded as 49 different S/P. Of these, 88 (28%) were S/P already included in the QLQ-C15-PAL, and patients seemed to list them to provide more detail (e.g., the location of pain). Almost half of the responses (153; 49%) were S/P not included in QLQ-C15-PAL, most frequently edema (15), dizziness (13), diarrhea (12), cough (8), sweats (8), impaired cognitive function (8), and existential problems (7). Finally, 36 (11%) of the responses were not S/P but diagnoses, and 38 (12%) could not be coded.
Conclusions: This new, brief instrument gives additional insight into the nature of S/P experienced by patients, and is thus a useful and recommendable supplement to the EORTC QLQ-C15-PAL.

PE 1.F15

Pain in older persons with severe dementia. Psychometric properties of the MOBID-2 Pain Scale

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Aim: To assess pain in older persons with severe dementia is a challenge due to reduced self-report capacity. The Mobilization-Observation-Behaviour-Intensity-Dementia (MOBID-2) Pain Scale is a nurse-administered pain instrument to assess inferred pain intensity, which is based on patients' pain behaviour in connection with standardised, guided movements of different body parts (Part 1), and pain behaviour related to internal organs, the head and skin registered on pain drawings and monitored over time (Part 2).
Methods: To examine inter-rater and test-retest reliability for pain intensity, internal consistency, as well as face-, construct- and concurrent validity of the MOBID-2 Pain Scale. Patients with severe dementia (N=77) were examined by 28 primary caregivers in clinical practice, who concurrently and independently completed the MOBID-2. Characteristics of the patients' pain were also investigated by their physicians (N=4).
Results: Prevalence of any pain was 81%, with predominance to the musculoskeletal system, highly associated with the MOBID-2 overall pain score (rho=0.82). Most frequent and painful were mobilizing legs. Pain in pelvis and/or genital organs was frequently observed in Part 2. Moderate to excellent agreement was demonstrated for behaviours and pain drawings (κ=0.41-0.90 and κ=0.46-0.93). Inter-rater and test-retest reliability for pain intensity was very good, ICC(1,1) ranging 0.80-0.94 and 0.60-0.94. Internal consistency was highly satisfactory; Cronbach's α ranging 0.82-0.84. Face-, construct- and concurrent validity was good. Overall pain intensity by MOBID-2 was well correlated with physicians' clinical examination and defined parameters of pain (rho=0.41-0.64).
Conclusion: Based on pain behaviours, standardized movements, and pain drawings, MOBID-2 pain intensity scores were shown to be sufficiently reliable, valid, and time-effective for nurses to assess pain in patients with severe dementia.

PE 1.F16

Screening for physical, psychosocial and spiritual distress among palliative cancer patients: Development and application of the FBPP

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Aims: Palliative care of cancer patients should meet their care needs. We aimed to develop a screening tool for the identification of their physical, psychosocial and spiritual burden to enhance the process of fulfilling their needs.
Methods: For the development of a distress questionnaire for palliative cancer patients ("Fragebogen zur Belastung onkologischer Palliativpatienten" FBPP) we used proven methods of scale construction:
(1) Analysis of existing distress questionnaires and equivalent literature,
(2) item modification in a panel of experts,
(3) a priori dimensioning and conception of a pilot form of the FBPP with 53 items.
These could be assigned to six categories: (Psycho-)somatic problems, anxiety, shortage of information, ADL limitations, social problems and existential/spiritual/religious burden. Further on we used some proven instruments for validity assessment. Patients of three centres for palliative medicine take part. In order to perform a Principal Component Analysis (PCA), a sample size of 160 participants is deemed necessary.
Results: Up to now about one third of the patients could fill out our pilot form (n = 68, age 39-85, 61% female). As heaviest burdens they marked somatic symptoms of their illness (87% fatigue, 85% weakness) and typical fears (65% of an excruciating dying, 59% of dependence). Spiritual and social problems burdened them relatively lesser (25% unanswered religious questions, 7% withdrawal of friends).
Conclusions: The FBPP assesses burden of cancer patients at the end of life. Its use may help to identify patients who require special palliative care interventions. Finally the PCA should lead to short and reliable FBPP-scales. Using the developed questionnaire may enhance the quality of palliative care.

PE 1.F17

Estimation of quality of life of palliative care patients by nurses, physicians and patients. A comperative study

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Discrepancies exist in estimation of quality of life (QL) by patients and caregivers. We performed a prospective, multi-centre, cross sectional study in which QL of patients in 20 palliative care units in Austria was estimated by patients, nurses and physicians using the EORTC QLQ-C15-PAL questionnaire. In addition, we evaluated a panel consisting of 38 variables which potentially could influence the accuracy of estimation of quality of life of patients (gold standard) by nurses and physicians.
153 patients (52 femal, 101 male) with a mean age of 69 years (range: 36 - 88) and a median Karnovski Index of 50 (Q1:30;Q3:60) completed the study. QL of these patients was estimated by 70 nurses (f: 83%,m:17%) nurses and 53 physicians (f:63%,m:37%). Both groups of caregivers had substantial concordance with patients with regard to physical functioning (r > .600).Both groups overrated patients in their social functioning with but underrate patients in their emotional functioning (nurses=.204; physicians:r=.304). A lower KI was significantly associated with low accordance concerning physical functioning, fatigue, pain and overall QL. In nurses, factors such as professional experience, specific training or regular supervision did not influence quality of ratings. Concordance with patients regarding "appetite loss" was inversely associated with years of professional experience (p=.028). Estimation of anxiety, which was significantly more accurate by female nurses and physicians, in estimation of anxiety which was significantly more accurate in male nurses and physicians and in estimation of physical functioning (p=.039), which was nearly perfect in males (r=.944) Our study revealed that estimation of overall LQ of patients is difficult but fair estimation of their specific LQ related problems is possible. Factors which influence this estimation have been identified.

PE 1.F18

Perceived burden of family caregivers of terminally ill cancer patients

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Background: International research shows that there is a need to focus on the burden perceived by family caregivers of terminally ill cancer patients. Thus, there is a need to develop burden assessment tools. In an intervention study of shared care between primary and specialised care for palliative patients, we indentified the "Burden Scale for Family Caregivers" (BSFC). However, no Danish version was available and no data on reproducibility and responsiveness were available. We aimed to make a standardised translation and adaptation of the BSFC and to measure perceived burden in a group of family caregivers of terminally ill cancer patients at time of inclusion and at one month follow-up.
Method: We translated the BSFC following the WHO guideline for translation and adaptation of instruments (1. Forward translation, 2. Expert panel, 3. Back translation, 4. Pilot tests, 5. Final version). The Danish version of the BSFC was subsequently applied to a group of family caregivers of terminally ill cancer patients, consecutively included from eight different hospital departments at the time of inclusion and at one month follow-up.
Results: We ended up with an applicable Danish version of the BSFC. Our data collection is still ongoing.
Conclusions: In the rigorous process of translating the BSFC according to the WHO guideline we experienced certain pitfalls concerning terms and words describing burden and care giving. These pitfalls and arguments for following the WHO guideline when translating a questionnaire will be presented.
Furthermore, preliminary BSFC scores for approximately 30 family care givers at baseline compared with scores at one month's follow-up will be presented together with preliminary psychometric properties.

PE 1.F19

Prognostic factors for survival using the interRAI PC in Iceland

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Aim: A lot of research has been done on prognostic factors for survival but this is the first published research using the interRAI PC, which is an assessment tool that has been developed for palliative care patients. The objective of this study is to identify potential prognostic factors that affect survival in palliative care patients using the interRAI PC and also to see how good Icelandic health care professionals are at predicting survival.
Methods: Prospective cohort study using patients, that were enrolled in our palliative care service between 15th october 2003 to 15th april 2004. InterRAI PC was used in data gathering. Statistical analysis was done with Kaplan-Meier and Cox Proportional Hazard model in SPSS.
Results: Of 124 patients (64 women and 60 men), five are still alive. Mean age was 71 years old. 116 patients had cancer and eight had miscellaneous. The most common cancers were GI and abdominal cancer (33%) and lung cancer (28%). Median survival was 41 days (95% CI 30-52). Further analysis will be presented.
Conclusion: Statistical analysis is not finished and this is preliminary data. No conclusion can be made at this point.

PE 1.F20

Assessing the competency of lay community caregivers to provide palliative care in a home based setting

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Aim: As part of a pilot project to expand the reach of palliative care into poorly resourced communities, it was necessary to assess existing skills of lay community caregivers providing home based care without professional supervision.
Method: A Caregiver Competency Assessment Tool was developed to assess a range of competencies key to the provision of palliative care at home. These included physical care, communication skills, end of life care, bereavement, infection control and record keeping. It was found that overall scores of the 30 caregivvers from 4 community organisations, were low. The average for physical care was 55 per cent, communication skills 45 and record keeping 25. These results informed the development of a training programme focussed on building key palliative care skills, after which an experienced palliative care nurse supervised the caregivers for the following 18 months and conducted monthly in-service training sessions.
Results: Results to date indicate a significant improvement in caregiver competency and confidence. An independant re-assessment, using the same tool, is currently being conducted and final results will be included in the presentation. A parallel process, using the African Palliative Care Association (APCA) Palliative Outcome Scale (POS), will dertermine patient and family perceptions of the quality of care and support.
Conclusion: In poorly resourced areas lay caregivers are vital in the provision of palliative care because of the scarcity of professional health care workers and the scale of the HIV/AIDS epidemic. It is essential to assess and enhance their competence in order to promote increased access to palliative care.

PE 1.F21

End of life informations obtained by a treatment survey. Preliminary data of AIO and AKS Colon Cancer Registry

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Aim: Using the AIO / AKS treatment database of colon cancer patients informations about end of life in this disease should be extracted. Charlsonscore (ChS), assessed in the database, was analysed.
Methods: AIO and AKS perform prospectively an epidemiological trial including 2500 patients who are intended to be treated in adjuvant (1000) or palliative (1500) intention. 70 outpatient cancer centers take part in the trial, 64 recruit actively patients. All patients will be followed for up to 5 years. In addition to oncologic data sets comorbidity data for all patients are documented and preliminary analysed focussing palliative care aspects.
Results: Acutally 2047 Patients are included. 1156 patients received a pallitative intended Chemotherapy. Only 45 patients (3.9%) with numberous comorbidities (ChS > 2) qualified for a standart chemotherapy. 280 Patients died during observated time. Multimorbid Patients were not overrepresented in this subgroup. Comparing dead and alive patients concerning comorbidity (ChS) no relevant diffenences between these groups could be found.
Conclusion: Further items must be assessed in AIO database to investigate end of life situation of colon cancer patients.

PE 1.F22

Comprehensive Geriatric Assessment (CGA). A new approach to subdivide elderly patients according to their functional parameters - Conception of IN-GHO®-registry

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Aim: Age is an insufficient parameter to define elderly patients (1). A selection of easy practicable geriatric assessments is investigated to subdivide elderly patients in those who sustain a full dosed medical treatment from those who need a dose reduction or those who should be provided to palliative care professionals.
Methods: Inclusion criteria for IN-GHO registry were age older then 70, malignant disease and a need for a therapeutic decision. Consenting patients were assessed with a comprehensive geriatric assessment (CGA) including Karnofski performance scale (KPS), Charlson comorbidity scale (CHS), Barthel Index (ADL), Instrumental Activities of Daily Living Score (IADL), Mini Mental State Examination (MMSE), Timed-up-and go Test (TUG) and Structured Clinical Interview for Depression (SKID). Clinical follow up is sceduled after 8-10 weeks- and finally after 6 month to investigate benefit or suffering of the patient due to the initial therapeutic decision.
Results: 1600 patients actually are included into the registry. CGA is accepted in patients and physicians due to the possibility to delegate the 20 minutes taking procedure to medical staff. Preliminary evaluations of patients with haematological illness show a predictive value of CGA (2).
Conclusions: CGA is a promising tool for a better therapeutic decision of elderly patients. Potentially palliative care aspects could earlier be involved in therapeutic strategy.

PE 1.F23

Taking care of the caretaker: The syndrome of therapeutic distress

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Concerns about QOL problems of health professionals are increasing recently and were interpreted in the frame of the known concept of burnout at work and were found to be related to: load at work, communication difficulties in team, low wages and lacking information. The typical burnout syndrome comprises of tension, irritability, depersonalization, thoughts about "escaping" the profession, etc. Our view is that this description does not stress enough special efforts of therapy provision that requires clearly treating the individual as a whole. This issue is especially acute in the palliative field. For a deeper study of the issue, pilot interviews were conducted with health professionals in different palliative units. Most referred to issues, such as the distress of identifying with the suffering patient, helplessness in confronting suffering, the necessity to communicate bad news to the patients and their families, dragging problems from work along to the family after work and inability to get rid of the extra pressure. Troubles of this kind are unique in palliative workers. As a result we suggest a new concept "therapeutic distress" for describing in a more focused manner the psychological state of palliative workers. It differs from the apparently similar concept of "compassion fatigue" (Figley) by being broader and more complete than empathic fatigue that is focused mainly on identifying with the suffering patient. A brief questionnaire was designed in order to explore, diagnose and assess therapeutic distress, referring to specific problems of palliative workers. Preliminary results are presented. The questionnaire was used in developing a supportive intervention program for workers in palliation. A program of this kind will enhance awareness of that specific issue and will refer to a set of skills intended to alleviate therapeutic distress when the first signs appear and to prevent its emergence even before the initial signs are detected.

PE 1.F24

Validation of the Spanish version of the ESAS (Edmonton Symptom Assessment Scale)

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The Edmonton Symptom Assessment Scale (Bruera E., 1993) consists of ten graphic numerical scales to examine frequent symptoms present in cancer patients. A Spanish version has not been validated as yet.
Aim: Validate the Spanish version of the ESAS in a group of advanced stage cancer patients.
A sample group of advance-stage inpatients and outpatients were selected from the Oncology department. The patients completed the ESAS on day 0, day 0 + 4 hours and on day 2. On day 0, the RSCL (Rotterdam Symptom Check List) was also filled in. Reliability was studied by determining internal consistency (Cronbach's Alpha) and stability using the test-retest. The concurrent validity with the RSCL was also studied, as was discriminant validity (Karnofsky<70 and >70 and inpatients and outpatients). Factorial analysis, sensitivity and feasibility were all measured. Internal consistency of the survey was measured for 171 patients by means of Cronbach´s Alpha, obtaining a coefficient of 0.75 (IC 95%: 0.70 to 0.81). The test-retest was performed for 146 patients, where Spearman's correlation on individual items was between 0.65 and 0.94. Factorial analysis was applied with oblique rotation in 171 patients, with three distinct components found in the survey. Concurrent validity of the ESAS with the RSCL was measures in 90 patients, correlating 7 items from the ESAS with corresponding items from the RSCL and correlations of between 0.55 and 0.76 were found. The survey's discriminant validity was measured in 171 patients with the Kruskal-Wallis test, to see if the scores on the ESAS were different according to different functional states and a significant difference ($p<0.005$) was found between groups. The survey's sensitivity was measured using the Wilcoxon test for the ESAS on days 0 and 2, where a significant difference ($p<0.05$) was found for the majority of symptoms.
The Spanish version of the ESAS is reliable, valid and sensitive for the detection of changes in a patient.

PE 1.F25

Functional dependent measure for cancer patient with some paraplegia

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Research aim: It is crucial for dignity of human-being including advanced or far advanced cancer patient to move with independently. But it is difficult to move independently because of paraplegia since they had metastases at spine or spinal cord. Therefore we studied more comfortable or easy way of moving for cancer patient with some paraplegia.
Study design and method: We selected patients with advanced or far advanced cancer in the field of palliative care in our institute from April 1998 to March 2008. They had any level of paraplegia because of their bone metastases of spine or spinal cord. We set a series of instruments such as bed with motor assisted, transfer board, module type wheel chair & a cushion which prevent bedsore and skilled support staff. At first, we put wheel chair by bed side where the patient lain.

Then we explained and instructed how to use transfer board to move to transfer. And we practiced transfer with transfer board with the patient. Finally, we had been evaluated by Functional Dependent Measure for Cancer Patient with Paraplegia (F.D.M.C.P.P.). The score of F.D.M.C.P.P. were from 0 (full dependent) to 100 (full independent.).
Results: Approximately ninety percent of objective patients succeed to use the way we showed them. Some patients could transfer with a board from bed to wheel chair independently that depends upon their sitting ability level. The score of F.D.M.C.P.P. were parallel to dependency of functional level at this time.
Conclusion: We set some knowledge, instruments, skilled staff and practice. There was no need to change physical ability of cancer patients in the field of palliative care. It is very important for advanced or far advanced cancer patients because of their time shortage and limitation of physical functional disability. We showed clearly in this situation by concrete score of F.D.M.C.P.P. which we developed.

PE 1.F26

Caregivers´ communication with patients about illness and death: Initial validation of a scale

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Caregivers of terminal cancer patients experience substantial communication difficulties with their loved ones about their illness. Existing communication scales focus on communication as perceived by the patient and do not include items that refer to his close death. The current study describes the development and initial validation of an instrument aimed at measuring caregivers' communication with patients about their illness and death. Two hundred thirty-six bereaved primary caregivers of cancer patients were recruited over a period of 18 months. The psychometric properties of the scale were explored by confirmatory factor analysis. Results provided support for a one factor solution. The discriminant and convergent validity of the responses to the scale were also supported. Future studies should further establish the validity of the scale with larger sample sizes and different populations of caregivers of patients with other terminal diseases.

PE 1.F27

Clinical indicators of a pressure ulcer in patients in palliative care: The actions of nursing home care

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Pressure ulcer (PU) is defined as injury to the skin or in adjacent tissue, usually on a bone prominence as a result of pressure or pressure in combination with shear force and the force of friction. The risk factors are: external factors - pressure, friction and shear and internal factors - tissue perfusion, age, mobility, activity, level of consciousness, excessive moisture, nutrition, hydration, chronic diseases such as diabetes and cardiovascular disease. The cancer treatment - surgery, chemotherapy and radiotherapy, as well as the malignant wound, are also important factors in assessing risk for developing PU. They are classified in stages from 1, 2, 3 and 4 according to the layers of tissue involved. This study aims to evaluate the performance of nursing actions, the patients in palliative care who developed cancer PU, through the clinical indicators in the sector of home care. In the period from January to September 2008 in a palliative care unit of cancer - Brazil. The study is a quantitative. Data were collected by the instrument and presented in tables and graphs. During the period there were 423 pressure sores. These 127 in stage 1, 197 in stage 2; 84 in stage 3 and 15 in stage 4. With the actions of nursing 20 pressure ulcers were healed, 200 improved from the first assessment, 39 worsened and 164 remained the same characteristics of the first assessment, the majority in stage 1 and 2. We can conclude that the actions of nursing had a good result, because even with low rate of healing, the aggravation of pressure ulcers was prevented. Well related to the debilitated clinical status of patients who are followed by home care, had maintained a large number of PUs staging 1 and 2, favoring the comfort and quality of life of patients.

PE 1.F28

"Has the patient been more confused lately?" A prospective study into the sensitivity of SQiD (Single Question in Delirium) screening

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Aim: To test the sensitivity of a single question in delirium screening (SQiD) against psychiatric interview (ψI). The Confusion Assessment Method (CAM), the Memorial Delirium Assessment Scale (MDAS) and the Mini-Mental State Examination (MMSE) were also tested against the SQiD and ψI.
Method: On a nominated day of multiple weeks, consecutive admissions to a university affiliated oncology, inpatient service, were screened for delirium. Of 33 admissions, 21 patients participated in the study. Consent was obtained and the single (SQiD) question: "Do you think [name of patient] has been more confused lately?" was put to the patients friend or family member. The CAM, MDAS, and MMSE were then applied. True cases of delirium were identified according to psychiatric interview (ψI) by a blinded investigator.
Results: The SQiD was positive for delirium in 8 out of 19 patients. The ψI identified 5 true delirium in 5 cases. The SQiD had sensitivity and specificity of 80% (95% CI 28.3% to 99.49%) and 71% (95% CI 41.90% to 91.61%) respectively. The CAM had a positive predictive value of (PPV) of 67%. The SQiD had a PPV of 50%. The SQiD and ψI had kappa correlation of 0.431 (p= 0.023). The CAM and ψI had a kappa value of 0.37 (p=0.050).
Conclusion: There is an urgent need to find practical methods of improving delirium detection. The SQiD has potential clinical utility as a simple screening question that could be incorporated into the admission routine of hospitalised patients. A further important finding was that our study showed the CAM had only 40% sensitivity in the hands of minimally trained clinical users. This contrasts the excellent sensitivity of the CAM when used by trained research staff. A larger sample size would allow further testing against ψI and could investigate the sensitivity of the SQiD in identifying hypo-active delirium and the specificity of the SQiD in distinguishing delirium from depression.

PE 1.F29

Symptom management performance checklist: Development of a new assessment instrument of oncologists´ interventions

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Aim: The inclusion of patient-reported outcomes - symptoms (SY) and clinical syndromes - in routine clinical decision-making practice of advanced cancer patients by oncologist (ONC) gains importance. Except tape-recorded and videotaped interviews, currently no assessment system monitors physicians´ SY management (Mgmt) interventions. To develop a SY Mgmt performance checklist (SyMPeC) for care and the E-Mosaic study (NCT00477919).
Methods: SyMPeC is based on current data on SY prevalence in advanced cancer patients and lists of typical interventions from textbooks of palliative care (PC) and oncology. SyMPeC includes data from anonymised medical charts, written prescriptions of ONC, and medical reports. It is developed by consensus processes of ONC & PC physicians including data from a variety of patients (SY priorities) and ONC (variable documentation practice). Finally, inter-rater reliability was assessed.
Results: SyMPeC consists of 4 hierarchical levels:
L1: Any intervention for pain, depression, anorexia/cachexia, fatigue, dyspnoe, nausea, or other.
L2: For each symptom, any pharmacological (Ph), diagnostic (Dg), or behavioral/counseling (BeCo) intervention.
L3: Intervention details (e.g., drug choice, diagnostic test).
L4: Detailed description (e.g., dose titration, partial rotations, specific sub-tests). During development, 15 charts were reviewed.
Inter-rater reliability among 3 PC physicians assessing 5 adult cancer patients (3 GI, 1 NSCLC, 1 H&N; main symptoms: pain [n=3], anorexia [2], nausea [2], fatigue, anxiety, dyspnea [1]) was >95% for L1 and for L2-4 only on Ph, on Dg and BeCo <80%, namely because ONC did not specify a priori reasons and goals; site-specific calibration phases of raters seem needed.
Conclusion: This novel, developing, instrument carries the potential to detect Sy Mgmt adaptations in clinical trials, to evaluate clinical practice guidelines, and to establish standards of best Palliative Cancer Care for anti-cancer treatment trials.

PE 1.F30

Use of the consciousness scale for palliative care as a prognostic factor

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Aim: A consciousness scale for palliative care (CSPC) was recently validated. In this study we try to find out if the levels of the scale have prognostic value.
Methods: We collected retrospectively the data recorded in the patients' files of our unit. The data analysed were only from ECOG 4 patients, as other patients has a high probability for a normal consciousness level. The method of Kaplan-Meier to determine the survival curves and the Breslow test to compare the length of survival were used.
Consciousness level scale:
1 Awake
2 Awakens when called by his/her name and keeps awaked during conversation
3 Awakens when called by his/her name but falls asleep during conversation
4 Reacts with movement or brief eye opening, but without eye contact, when called by his/her name
5 Reacts to trapezius muscle pinching
6 Does not react.
Results: There were 421 observations in 135 patients; in 261 (62%) of the observations the patients had an ECOG performance status of 4. From the patients ECOG 4, 48 (59%) were male and 33 (41%) female. The median age was 69 years (23 to 87). There were 256 observations assessable: level 1 - 175; 2 - 16; 3 - 33; 4 - 17; 5 - 10; 6 - 2.
As the numbers in most levels were very low for analysis, levels 1 and 2, 3 and 4, 5 and 6 were merged in 3 groups. The analysis of the 3 groups revealed a median survival of 24 days (CI 95% 18-30) for the first group, 11 days (CI 95% 6-16) for the second and 3 days (CI95% 1-5) for the third (p <0,001).
Conclusion: This analysis showed that the consciousness levels of the CSPC have prognostic value when merged in 3 levels. A much higher number of observations will be necessary to see if all levels of the scale are relevant to that goal, what can be a different kind of validation of the scale.

PE 1.F31

How should meaning in life be assessed? A systematic review

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Background: Meaning in life has become increasingly important in Palliative Care. If patients with terminal illnesses are able to maintain or regain meaning in life, they are more likely to experience their remaining lifetime as worth living. Psychotherapeutic interventions in palliative care aim to improve patients' meaning in life. The present systematic review looks at published instruments for meaning in life assessment.
Methods: Key words were meaning in/of life, purpose in/of life, sense in/of life, meaningful/purposeful life, personal meaning, meaning system, meaning/ful existence. Electronic databases were searched up to August 2008: Ovid Medline 1950-2008, Embase 1988-2008, Cinahl 1988-2008, and PsychInfo 1806-2008. Retrieved studies were evaluated using the criteria of the Scientific Advisory Committee of the Medical Outcomes Trust.
Results: The search strategy yielded 4997 hits. Starting in the 60s, there is a steady increase in newly published or revised instruments per decade. Overall, more than 50 different MiL instruments were identified. They either measure the extent of perceived meaning in life, the specific sources of meaning, meaning structure, search for meaning in general as well as search for meaning in illness. Meaning sources are most often assessed nomothetically, i.e. between 7 and 26 different sources of meaning are provided by the researcher and rated by the patient. Some newer instruments allow for patient-generated assessment of meaning in life (idiographic method).

Conclusion: Meaning in life is operationalized in different ways: Some authors conceptualize meaning in life as unidimensional, while others postulate bi- und multidimensional constructs. Wong's model comprising a cognitive, emotional and motivational component of meaning in life proves useful for a clearer understanding. Idiographic methods seem to allow for a more individualized assessment of this highly personal construct.

PE 1.F32

The assessment of specialist palliative care need: A common language

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The Manual of Cancer Services Standards & NICE Guidance for Supportive & Palliative Care require that specialist palliative care need is assessed holistically and that the assessment includes physical, psychological, social, spiritual, information and carers' needs. The recommendations also state that this full range of holistic need should reviewed and assessed by the full multi-professional team at weekly multi-disciplinary team meetings.
In 2005 the Saint Francis Hospice community team began using an adapted model of the Support Team Assessment Schedule, otherwise known as STAS, to support the implementation of these national recommendations.
The Support Team Assessment Schedule was developed in 1993 by Irene Higginson as a clinical audit tool, in response to a developing requirement for data to be made available nationally to measure the level & quality of palliative care provision. At Saint Francis an adapted version of the tool was implemented by the community palliative team to establish a uniform standard of assessment of specialist palliative care need; to provide a framework for the assessment and review of patients at the weekly multi-disciplinary team meeting and rationale for decision-making.
As a result of the success of the community team, demonstrated by an end of year audit and enhanced multi-professional team working, a decision was made to roll the tool out across the organisation. A unified standard of assessment across the organisation provides a common language and ensures that all patients, in whatever department they are being cared for, are assessed and reviewed holistically, multi-professionally and against the same criteria.
Using STAS in this way also provides an excellent ability to demonstrate the appropriate use of specialist palliative care services and a means of demonstrating the outcomes and quality of services.

PE 1.F33

Have the functional state and the mental state of patient influence on the overload of caregiver during the staying in a palliative care unit?

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Introduction: One of the reasons for admission to a hospital PCU is caregiver burden. This time may coincide with the increasing degree of dependence of the patient or with the deteriorating of mental state. The admission to a hospital PCU may represent for the main caregiver an improvement in their perception of overload.
Objectives: To assess the degree of functional dependence and mental state of the patient, and overloading of the primary caregiver at admission.
To verify if there is relation between these variables at the time of entry and along its evolution.
Method: Evaluation by Barthel scale (functional dependence), Pfeiffer index (cognitive impairment) and reduced Zarit index (overloading of the caregiver) on days 1st, 10st, 20st and 30st of the hospitalization.
Inclusion criteria: All patients admitted.
Exclusion criteria:
1) Patient in agony.
2) Refusal / Absence of the caregiver.
3) Refusal of the patient.
Criteria for abandonment:
1) Death.
2) Discharge from hospital.
3) Transfer to another center or home.
Results (preliminary): Average scores in the different scales along the income:
- Barthel (0-100): 38.18 (1st day), 33.17 (10th day), 35.17 (20th day), 33.95 (30th day).
- Pfeiffer test (0-10): 3.2 (1st day); 3.5 (10th day), 3.82 (20th day), 3.83 (30th day).
- Reduced Zarit index (7-35): 24.87 (1st day), 21.88 (10th day), 18.97 (20th day), 16.88 (30th day).

Conclusions: There was a 56.37% losses throughout the study, all by death. There was a small decrease in functional ability, measured by the Barthel scale, from 38 to approximately 33%.
The rate of errors by cognitive impairment, measured using the index of Pfeiffer, increased from 3.2 to 3.8 throughout the study.
The overloading of the caregiver decreased significantly throughout the study (Zarit I. from 24.8 to 16.8).

PE 1.F34

SPARC - A screening tool which identifies holistic needs of cancer patients

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Aims: To identify holistic supportive and palliative care needs in cancer patients at all stages using the screening tool SPARC and other standard quality of life and symptom scales.
Method: We conducted a prevalence survey of holistic needs in hospital inpatients and outpatients. Cancer patients aged over 18 years were invited to complete SPARC, a 45 item screening tool for holistic needs. This covers: physical symptoms (21 items), psychological needs (9), religious/spiritual (2), independence/activity (3), family /social (4), treatment issues (2), information/communication (3), personal affairs (1). Patients also completed EORTC QLQ-C30 and other instruments if reporting specific symptoms.
Results: 326 patients (55% female; 189 outpatients, 137 inpatients) took part. Performance status: 0=6.4%, 1=50%, 2=16%, 3=24.5%, 4=3.2%. 64% were receiving chemotherapy, 29% radiation therapy, 6% hormone therapy. Many patients had co-morbidities including heart, lung and kidney disease, arthritis, diabetes. 80% had no preference between SPARC and EORTC QLQ-C30; of the rest, 60% preferred SPARC and 40% EORTC. Patients had significant symptom load: pain (57% a little-very much); weakness (76%); tiredness (88%); drowsy during day (82%); problem sleeping at night (70%). Other issues identified: feeling anxious (70%); low mood (60%); life is not worth living (10%); worrying thoughts about death and dying (40%); sexual problems (20%). 50% were bothered by losing independence and 70% by inability to do household tasks. 80% were worried about effects of illness on family. 40% were worried about side-effects and 50% about long-term effects of treatment.
Conclusion: SPARC is well accepted by cancer patients at all stages. It identifies a very broad range of holistic needs. It is now the standard assessment tool in our cancer network for all patients at key stages of their illness. A training programme and manual to use SPARC is being prepared.
Funding: Charity and pharmaceutical company.

PE 1.F35

Symptom management by a community palliative care team

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Aim: Assessing the effectiveness of symptom management by a community palliative care team (CPCT).
Method: There are "difficulties in applying an evidence-based approach to palliative care" (1). Research in palliative care (PC) is controversial and difficult to carry out. Evaluation is an alternative method to strengthen the evidence base of PC. Hence, a service evaluation was carried out to see whether the CPCT was being effective. A modified version of the Support Team Assessment Schedule (STAS) was used, after comparison with other tools clearly showed that it was the most appropriate to use in a community setting. During a predefined time period of two and a half months, all new cases referred for community PC were included in the evaluation. The STAS was delivered at referral, and subsequently every two weeks for a total of three assessments.
Results: Of the 56 newly referred patients, only 34 managed to complete three assessments. The STAS scores of these 34 patients were analysed. There was a significant (1.7, p=0.039) reduction in overall mean STAS scores, with non-significant reductions in individual item scores. In contrast, the symptom prevalence of patients remained unaltered throughout the evaluation. Male patients exhibited greater overall reductions in STAS scores (3.27, p=0.029) as opposed to female patients (0.47, p=0.597).
Conclusions: The CPCT under review reduced the physical distress of patients, but there is room for improvement, given that symptom prevalence is unaltered. Explanations for such findings include lack of awareness of the present service to other stakeholders, problems with access to relevant medications and suboptimal medical input in the modus operandi of the team. Future research could address gender differences in response to treatment.
References: (1) Higginson, I.J. 1999, "Evidence based palliative care: there is some evidence - and there needs to be more", British medical journal, vol. 319, no. 7208, pp. 462-463.

PE 1.F36

Study to investigate to what extent palliative care units in London and the SouthEast of England are following the European Association for Palliative Care guidelines for the management of malignant bowel obstruction

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Aim: Malignant bowel obstruction (MBO) is a distressing complication of certain types of advanced cancer (eg. gastrointestinal, gynaecological). In 2001, the European Association for Palliative Care (EAPC) published a set of clinical recommendations on the management of MBO based on the available evidence in the literature and also "expert opinion" from leading palliative medicine physicians. The aim of this study was to determine adherence to the EAPC recommendations amongst palliative care services in London and the South East of England.
Method: All (148) adult palliative care services (ie. hospice inpatient units, home care teams, hospital support teams) in London and the South East of England were contacted, and asked whether they had guidelines on the management of MBO, and (if so) whether they could send the investigators a copy of these guidelines. The local guidelines were compared to the EAPC recommendations by 2 independent investigators using a specially developed proforma. The areas reviewed included investigation, surgical management, medical / pharmacological management, and supportive care (eg. fluid replacement).
Results: The local guidelines have now been received, and are being reviewed by the investigators. This review process will be completed by the end of November (2008), and statistical analysis completed by the end of December (2008). It appears that the guidelines vary from unit to unit, with some agreement amongst neighbouring units, and some agreement with the EAPC recommendations.
Conclusion: The study will provide evidence of the current strategies for management of MBO in the South East of England, and particularly the influence of the EAPC recommendations on the management of MBO in this region of the UK (and probably the whole of the UK).
This study was funded by the NHS.

PE 1.F37

Prescribing and monitoring of corticosteroid use within palliative care - An audit

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Background: Corticosteroids have several indications within palliative care and dose depends on the indication. Due to potential suppression of the adrenocortical axis and risk of side effects, doses and reducing regimes need monitoring.
Aims: To review steroid prescribing in a hospice and compare with guidelines and literature. To develop guidelines and care pathway for use when commencing steroids and re-audit following their implementation. To investigate the use of the pathway within the community and hospitals.
Method: Retrospective review of case notes of 50 consecutive discharges and deaths. Inclusion criteria were malignant disease and use of steroids. Data collected included demographics, dose of steroid,

review dates documented and completed, gastric protection, osteoporosis prophylaxis and blood glucose monitoring.
Results: Median age 71 years (range 35-93). 16 patients had a malignancy and were taking steroids during admission. The most common diagnoses were colorectal carcinoma (25%) and prostate carcinoma (25%). Anorexia (31%) and nerve compression (19%) were the most common indications however this was unclear in 4 patients (25%). Review dates were documented in only 5 patients. Despite this, doses were reviewed appropriately in accordance with perceived best practice in all but 2 patients. 3 patients suffered from oral candida and 2 developed oedema. Blood glucose monitoring occurred in only 2 patients. Osteoporosis prophylaxis was indicated in 1 patient however not prescribed. Gastric protection was not prescribed in 4 patients (25%).
Conclusion: Review dates are rarely documented and monitoring or treatment of side effects is infrequently completed, placing patients at risk. Clinical guidelines and a care pathway have been agreed within the multidisciplinary team and implemented within the hospice. We intend to re-audit and with these results investigate the possibility of transferring the guidelines and care pathway to the hospital setting.

PE 1.F39

Evaluation of a bereavement evening service in a London hospice

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Bereaved relatives are invited by a London hospice to attend an evening event about 3 months after the death of the patient. This event consists of a talk by a member of the psychosocial team on common responses to bereavement, followed by small group discussions facilitated by members of the hospice staff or a bereavement service volunteer.
Bereaved relatives (n=105) who attended 5 monthly bereavement evenings were given a feedback questionnaire to complete. All those who were invited but did not attend (n=436) were sent another questionnaire to find out the reason for their non attendance. 59 (56%) participants responded as did 184 (42%) of those who did not come. Most participants said their reason for coming had been to meet others in a similar situation and to share experiences of bereavement (n = 41 or 69%). Nearly half (n=28 or 47%) said that they had ´just come along not knowing what to expect´. Many commented that the talk helped participants to feel that their grief reactions were normal and it lessened their sense of being alone in their bereavement.
The options most frequently selected by non attenders as reasons for not coming were ´I did not think it would be helpful to me´ and ´I am already receiving support from elsewhere´. 92% of respondents who did not come thought there was nothing the hospice could have done to make it easier for them to attend. There were a few suggestions as to how to improve the events, relating mainly to timing and organising the groups according to type of bereavement (this suggestion came independently from 3 bereaved spouses aged 41-55).
Overall the bereavement evenings were valued by respondents who participated, and even those who did not attend appreciated having been invited, seeing it as further evidence of the care extended to them by the hospice.

PE 1.F40

How is end-of-life care performed in a Norwegian teaching hospital?

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Aim: Our hospital is a large teaching hospital with 950 deaths per year. We wanted to study how end-of-life care was provided at the hospital before introducing a palliative care consult service, and identify areas for improvement.
Material: All palliative care cancer patients (pts) who died at the Departments of Surgery and Oncology Jan-June 2006, 78 in all (34 females, 44 males).
Method: Retrospective study of all parts of the medical record for the last 3 months of life. 22 variables were recorded: Background information and suggested quality indicators from the national Standard for Palliative Care (2004).
Results: The pts had on average 2.6 (1-10) admissions and 23.3 days in hospital; the last admission lasted 13.3 (1-49) days. 88.5% were admitted from home. Each patient was attended by 2-17 different doctors, on average 7.5. 42 pts were seen by a physiotherapist, chaplain and/or social worker. 13 pts were referred to the pain clinic, 22 to a specialist palliative care service nearby, and 45 to the hospital's ambulatory support nurses. 38 pts had a family meeting. No patient had an individual care plan, and a joint meeting with the primary care services was held only once. 24 pts had completed at least one symptom assessment. Only 3 records had a doctor's note with a long term plan for symptom relief.
33 pts had a blood sample drawn during the last 48 hours, while chemotherapy and iv nutrition had been discontinued in almost all cases. Imminent death was recorded in 28 cases; in 20 cases the patient was informed. Medications for symptom relief in the dying could be evaluated in 66 cases and had been given in 61. 67 pts died in the presence of their close ones; 6 died alone.
Conclusion: Several areas for improvement were identified. More attention should be given to symptom relief earlier in the disease trajectory. The staff also needs to improve their skills in recognizing the dying phase and let this observation guide all further actions.

PE 1.F41

Audit of discharge planning and delays in discharge of in-patients at a specialist palliative care unit

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Palliative Care patients have complex needs, which change as they progress through their disease journey. Discharge planning involves many different factors, and trying to co-ordinate and plan a safe and successful discharge can often be frustrating.
Aim: The aims of this study were:
1) to examine discharge planning in a specialist Palliative Care unit, and
2) to ascertain what, if anything, is delaying discharges.
Methods: A prospective survey of all in-patients in a Specialist Palliative Care unit was carried out over a two month period. Documentation of discussion of discharge planning, requirements necessary for discharge to take place, planned and actual discharge dates with reasons for any variation in dates were noted.
Results: A total of 39 in-patients were included in the audit, and mean length of admission was 17 days. 20 patients had their future care planning discussed regularly. Discussion was not appropriate in 7 patients who had been admitted for end of life care. 18 patients were discharged on the planned date, and 12 patients had their discharges delayed.
Conclusion: A significant number of patients (31%) had their discharges delayed for varying reasons. Delay in appropriate care package being available was an issue, other reasons being complexities within the family situation and changing needs of patients. Delays have a huge impact on patients and their families in what is already a stressful time, and may mean they are not able to be cared for in their place of choice.

PE 1.F42

Standards for social worker in palliative care in Sweden

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Background: The Association for social worker in palliative care in Sweden was founded in 2003 and currently approximately around 50 members. The aim was to create standards for social workers in palliative health care, in order to define what the social worker shall do, as well as the need of competence and education.
Aim: To create standards for social worker in palliative care.
Method: The board of the association finds standards for social workers in other areas of health care and submits a proposal for standards to the associations annual meeting. A smaller group meets to discuss the importance and the purpose of such standards. During the following meeting 2007 the standards were presented for all members. After a new discussion the standards were approved as qualities criteria for the social workers in palliative care.
Results: The standards emanate from the WHO:s Declaration for Palliative Care. The standards contain issues like: ethical questions and way of meeting patient and loved ones, competence, measures, teamwork, authority, education, supervision and research.
Conclusion: Using similar standards for all social workers in health care, can give the social worker a platform to increase the quality of the work with the patient and the loved ones. It is also a document for the employer when staff is recruited. For the newly employed social worker the standards may be helpful to understand what social work in health care comprises. The standards can also be a tool to ensure quality of the social work throughout the whole country.

PE 1.F43

Managing agitation at the end of life: How much sedation is required in different care settings?

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Aim: To assess the most commonly used types and doses of sedative medication given for control of agitation in the last 24 hours for patients who died in a hospice, a hospital advisory and a community setting, according to the Liverpool Care Pathway of the Dying (LCP).
Method: Retrospective case note review of 87 patients (41 female), who died within the catchment area of a specialist palliative care service (n=30 on specialist palliative care unit, n=27 on wards of large university hospital and n=30 community setting). Data below indicate percentage of patients, median dose of syringe driver medication over 24hours, breakthrough frequency.
Results: The most commonly used drug for sedation was midazolam in all three settings. More patients (83%) on the specialist unit and the community setting (73%) received midazolam than in the hospital setting (22%) in the last 24 hours of life. Median midazolam doses over 24 hours were low in all three settings (15mg palliative care ward, 10mg community, 10mg hospital). 66% patients on the specialist unit required additional breakthrough doses of 2.5-5mg Midazolam to treat agitation, 23% in the community and 15% in the hospital setting. Levomepromazine was the second most commonly used sedative. Similar to midazolam, doses were low with medians of 25mg, 12.5mg and 12.5mg over 24 hours respectively. Breakthrough doses of 6.25mg for control of agitation were given in 20% of patients on the specialist unit, 3% in the community and none in the hospital.
Conclusion: This audit highlights that agitation at the end of life can be managed effectively with usually low doses of sedatives with help of the LCP. Higher doses of sedatives were required on the specialist palliative care unit possibly reflecting the complexity of patients managed there.

PE 1.F44

Audit of the prescription of strong opioids at the point of referral to specialist palliative care

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Aim: A review of the prescription of strong opioids at the point of referral to specialist palliative care (SPC).
Method: Data was collected on consecutive patients already prescribed strong opioids at the time of referral to hospital SPC teams. Anonymised data about the prescription of opioids, use of adjuvant analgesia and possible opioid side-effects was collected and analysed descriptively.
Results: Data was collected on 89 patients, aged 27 - 95 years (mean 67 years). The most frequent diagnoses were lung, colorectal and prostate cancer. For those patients who had a pain score recorded the mean score was 5 out of 10. The majority (96%) of patients were prescribed strong opioids for management of pain. 64% were also prescribed adjuvant analgesia. 52% of analgesics had been titrated according to the WHO

ladder and only 46% of opioids had been correctly titrated according to breakthrough analgesia given. 95% of patients had breakthrough analgesia prescribed but only 78% of these were at the right dose. The majority of doses that were prescribed incorrectly were too high. 70% of patients were prescribed aperients and 66% of patients were prescribed anti-emetics.
Conclusion: Around two thirds of cancer patients will require strong opioids to alleviate pain. Of these patients approximately 88% can have their pain adequately controlled if the basic principles outlined in the WHO guidelines are followed.
The majority of patients with cancer-related pain are seen by generalists who manage their pain and other related symptoms.
The prescription of strong opioids should be a generic skill for all doctors however this review showed there is still improvement to be made. Specialist palliative care teams have a role in providing education and the chance to influence the medical curriculum, both undergraduate and postgraduate, to ensure that everyone has the skills needed to provide patients with adequate analgesia.

PE 1.F45

Audit of diagnosis and management of anaemia in patients referred to a hospital support team for palliative care

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Background: Anaemia is common in palliative care patients and the cause may be multi-factorial. The main challenge is distinguishing between anaemia of chronic disease (ACD) and iron deficiency anaemia (IDA). Ferritin is the most useful discriminator with values of <40µg/L in the absence of inflammation or <70µg/L with inflammation being highly predictive of IDA.
Aim: Review the literature and develop criteria and standards against which to audit current practice.
Method: 100 consecutive patients referred to a hospital support team for palliative care. Anaemia was defined as a haemoglobin below laboratory's normal limits. MCV was noted as was details of any further haematological investigations and management of those with anaemia.
Results: Forty-two patients were defined as anaemic. 21% had further investigations. 35 of the 42 had a normocytic anaemia and 6 of these were receiving iron. Five patients had a microcytic anaemia. Two of these had a ferritin measured and were on iron in spite of ferritin values indicating ACD was more likely than IDA. Three months later, only one of the 42 anaemic patients was still alive.
Conclusions: Anaemia is common in this group of patients, is usually mild and is often not appropriately investigated or treated. Symptoms such as fatigue and breathlessness may be due to underlying pathology not anaemia. Iron is not a risk free treatment and causes significant side effects. Management of this group of patients requires pragmatism and careful analysis of benefits and burdens.

PE 1.F46

First home visit to patients referred to a specialist palliative care team. Patient characteristics and symptoms, team interventions and use of resources

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Background: It is commonly accepted that 20-30 % of palliative cancer patients need specialist palliative care intervention. This study was performed to describe the patient referred to a specialist palliative care team with strict criterias for referral.
Referral criterias to team include: Palliative patient with complex symptoms / problems with needs that exceed the common efforts of the professionals involved at basic level of palliative care (GP, home care service, hospital staff etc.).
After receiving a referral we require the patent's complete hospital file and often call the refering doctor to clarify the needs of the patient before we arrange our first home visit which is always performed by a doctor and a nurse, usually the home care nurse takes part as well. The aim of this first visit is to create an overview of the patient's situation and needs and to make a plan for the treatment, help and support needed.
Method: For each patient was registered:
• Age, sex, cancer diagnosis
• Results of symptom screening using EORTC QLQ-C15-PAL questionnaire
• Other important symptoms / problems
• Duration of the home visit and transportation to the patient's home
• Change in medication
• Prescription of new medicine
• Phone contact to pharmacy, general practitioner, home care nurse, hospital
• Involvement from other professionals from the team or other
• Hospital admission, referral to hospice or other services
• Volunteer involvement
• Follow up time, place of death.
Results:
- 97 patients have been registered.
- 71 (73%) had filled in the EORTC questionnaire.
- More than half of the patients scored maximum for difficulties walking short distances, has to stay in bed or chair during day time, feel tired, the symptom burden was generally high.
The study is ongoing and detailed data from appr 150 patients will be presented at the congress.

PE 1.F47

Changes in anti-cholinergic load from regular prescribed medications in palliative care as death approaches

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Introduction: Although there is an understandable emphasis on the side effects of individual medications, the cumulative effects of medications have received little attention in palliative care prescribing. Anti-cholinergic load reflects a cumulative effect of medications that may account for several symptoms and adverse health outcomes frequently encountered in palliative care.
Methods: A secondary analysis of 304 participants in a randomised controlled trial had their cholinergic load calculated using the Clinician Rated Anti-cholinergic Scale (modified version) longitudinally as death approached from medication data collected prospectively by study nurses on each visit. Mean time from referral to death was 107 days, and mean 4.8 visits were conducted in which data were collected. Relationships to key factors were explored.
Results: Data demonstrated that anti-cholinergic load rose as death approached because of increasing use of medications for symptom control. Symptoms significantly associated with increasing anti-cholinergic load included dry mouth and difficulty concentrating ($p < 0.05$). There were also significant associations with increasing anti-cholinergic load and decreasing functional status (Australian Modified Karnofsky Performance Scale; and quality of life ($p < 0.05$).
Discussion: This study has documented in detail the longitudinal anti-cholinergic load associated with medications used in a palliative care population between referral and death, demonstrating the biggest contributor to anti-cholinergic load in a palliative care population is from symptom specific medications, which increased as death approached.

PE 1.F48

Development of a computer-based documentation system for palliative care units

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In German-speaking areas there is a lack of standardized documentation systems for palliative care units for the routinely use in daily practice. The aim of our project was to develop a computer-based structured documentation system which is able to collect longitudinal data on palliative care units.
After literature research and first own experiences, we identified relevant medical and structural (e.g. duration of stay, frequency of admission) characteristics. Symptom assessment as well as medical, limited nursing and psychosocial procedures were also defined as important issues. The items are partly based on published data. For the data sampling an electronic database was developed. The implementation at the palliative care unit, evaluation of its practicability and acceptance of the medical staff was the main aim of the project.
After six months the implementation of the documentation system was successful regarding practicability and acceptance of the medical staff. The analysis of the first data will be presented.
We were able to develop a practicable electronic database for palliative care units. The analysis of the data will show, if they reflect the specific requirements of palliative care. This documentation system could be used for the comparison of the different structures of palliative care units and could be the basis for further research projects. The extension to other institutions is planned.

PE 1.F49

An assessment of the implementation of palliative care standards in South African hospices

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Aim: The Hospice Palliative Care Association (HPCA) and the Council for Health Services Accreditation of Southern Africa (Cohsasa), developed comprehensive palliative care standards to promote quality in organizational management and care delivery in member hospices. Levels of compliance are assessed during surveys, with 80% in each relevant service element required for full accreditation. HPCA recently assessed the value of the process when measured against the time and resources required at both national and local hospice levels.
Method: A review was conducted of the standards, surveys and linked mentorship process. Meetings were held with 20 fully accredited member hospices to assess perceptions of the benefits and challenges and to identify areas for improvement. An analysis of all survey results was also conducted to assess the progress of member hospices towards compliance with the standards and to identify areas requiring additional mentorship and training. Standards alone are of limited value in ensuring quality in palliative care and surveys and mentorship are integral to their implementation.
Results: Key benefits included the provision of norms for quality care and management, enhanced credibility, access to donor funding, staff and organizational development and the promotion of quality improvement. The need for a detailed introduction and suggested language changes are being addressed. An analysis of individual hospice survey scores indicated and overall improvement in management and care and a commitment to quality improvement.
Conclusion: Evidence of compliance with recognized standards is positioning South African hospices as palliative care resources, making a significant contribution to HPCA's vision of Palliative Care for All.

PE 1.F50

Development of a statewide database for quality monitoring and improvement in palliative care

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Aims: To create a regional palliative care database that
(1) supports quality assessment and monitoring,
(2) enables longitudinal tracking of outcomes,
(3) is practical in diverse settings,
(4) meets reporting requirements,
(5) captures consensual data elements for responding to future metrics.
Methods: A community-based hospice/palliative care organization and an academic medical center are developing a database infrastructure for clinical palliative care, quality monitoring, and research. In stakeholder meetings, we agreed on a modular approach (core data elements plus scenario-specific customized data elements), developed a data dictionary, and created and field-tested data collection forms. After exploring different systems, we selected a relational database as the most practical and facile solution. The architecture serves clinicians' needs, meets security requirements, and accepts data through a variety of data collection platforms including tablet computers and digital pens. We developed software, secure data

transfer procedures, and data control procedures. Data travel from the community site to the academic site for analysis and reporting; iterative feedback informs system refinement and directs analytic inquiries.
Results: In 3 months, data on 252 patients were collected by 6 nurse practitioners and a medical champion at the community site, who entered data at point of care. The system generated preliminary data tables reporting symptom frequencies and severity over time. Data have been mapped to recently developed palliative/hospice care quality metrics.
Conclusions: Creation and use of a palliative care database is feasible at a community site without pre-existing electronic data capture. Important lessons learned include: stakeholders' needs must be addressed; the system must be flexible and easily used by diverse institutions/users; the system must be scalable and expandable; a palliative care database could inform statewide service planning.

PE 1.F51

Level of satisfaction of caregivers attended by a support palliative care team in a teaching hospital

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Objective: To know the degree of satisfaction of caregivers attended by a support palliative care team.
Method: Prospective and descriptive post survey. Population: all the patient relatives seen by our team between January and December 2007, excluding those not been discharged from our service and/or those with no next of kind. Mailing post was done on September 2008. The inquiry had two differentiated parts; the first included data regarding the relative who answered. In the second part included 11 closed questions related to the patient's symptom control, emotional support and the degree of help received. The inquiry offered the possibility of comments and suggestions. Descriptive statistics were used to summarize respondents' characteristics.
Results: A total of 379 were sent. At 30 days 99 (31.7%) answers were received with the following characteristics: 77,7% were women with a mean of age of 58,3 years (range 29-83). Relationship to patient: spouse 43,9% and child 44,9%. Scholarship: 51,1% primary school and 31.8% secondary school. 86,7% of respondents agreed the patient had a good pain control. 80% of the caregivers consider that patients quality of life, death, information and relation with the team was satisfactory. The 67.3% of relatives had the feeling that they were grieving in an adequate manner. 38.8% said that they have not received enough help to solve hanging topics. The mean of satisfaction perceived was 7.7/10 (median: 9; range (0-10).
Conclusions:
1. The level of satisfaction perceived by responders is globally high.
2. The degree of satisfaction related to symptom control, quality of life, information, relation with the team and death is also high.
3. It seems that the attention related to solve hanging topics did not respond to the expectations in a small group of relatives and can be improved.

PE 1.F52

Retrospective audit of acute sickle painful crisis

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Background: Painful crisis is commonest cause for admission to hospital but remains a point of friction between medical staff and patients. Inadequate control may lead to chronic pain syndrome. Management of pain primarily involves opioids and adjuvants.
Aim: To determine:
1) the number of patients with sickle cell crisis admitted to hospital in one year;
2) the length of stay and the number of readmissions;
3) analgesia used;
4) adverse effects;
5) observation parameters,
6) involvement of the Palliative Care Team, and
7) compliance to national guidelines.
Results: There were a total of 21 admissions (9 patients) with acute pain. 5 patients had only one admission. Male to female ratio was 4:5. 47% of these admissions presented out of working hours. Observation parameters were monitored satisfactorily. 81% received analgesia within 30 minutes of arriving in hospital. There was no consistent pattern of opioid use with different route of administration applied. Also 'adjuvant' medication like laxatives, anti-emetics were not routinely prescribed. The Palliative Care Team was involved in 67% of the admissions.
Conclusion: Management of sickle pain is broadly in line with the British Committee for Standards in Haematology guidance. A recent NCEPOD (National Confidential Enquiry into Patient Outcome and Death) report highlighted problems with adverse effects of opioids, however our patients are closely monitored and there is ample evidence of good nursing practices. We have developed hospital guidelines to try and standardize the treatment of pain in patients with sickle cell crisis and also designed an assessment tool to monitor pain scores and adverse effects.

PE 1.F53

Hospice friendly hospitals - Developing an audit and evaluation strategy for a national programme

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Background: The Hospice Friendly Hospitals (HFH) programme in Ireland is designed to change hospital cultures of care and organisation relating to death, dying and bereavement, using a 'systems level' approach. A national intervention on this scale poses significant evaluation challenges.
Aims: To conduct baseline (2008/9) and follow-up (2011/12) comparisons to assess the extent to which intermediate outcomes (improved standards in the organisation and culture of end of life care) and final outcomes (improved end-of-life experiences for patients and families) have been achieved.
Methods: Five categories of data inform the assessment of HFH effectiveness in achieving its goals:
1) Context
2) Caring climate
3) Standards
4) Patient outcomes
5) Programme inputs.
Statistical analysis using Multi-Level Modelling will be used to separate individual-level and hospital-level influences, both at baseline and follow up.
Results: We report on the findings of a pilot study in nine hospitals, from which the following key lessons emerged:
1) Each hospital to identify a designated manager to oversee the evaluation
2) An electronic database and instruction document required for tracking the 6 questionnaires that make up the evaluation
3) A briefing session needed in each hospital for ward managers and those contacting bereaved relatives.
4) All materials to be assigned a 'Plain English Mark'.
Conclusions: The evaluation of HFH has created conceptual and practical challenges. Key to success is the extent to which participating hospitals can integrate the demands of the evaluation into routine audit activities, thereby minimising burden and increasing compliance.

PE 1.F54

Access to interventional pain management- available to all who need it?

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Background: Approximately 10% of cancer pain patients are said to require interventional pain management techniques. National guidance has stated that local specialist palliative care teams should have access to an anaesthetist with expertise in nerve blocks and neuromodulation techniques, and that each cancer network should have a named lead specialist for advanced pain techniques. The literature also recommends a joint approach in assessment of these patients between pain and palliative care specialists.
Aim: To assess the availability, referral practice and levels of joint working within a large cancer network in the U.K.
Methods: A survey was sent out to all service leads of specialist palliative care services within Merseyside and Cheshire Cancer network. Questions included type of pain service available, number of referrals, barriers to access of pain service and issues around specific education.
Results: 90% of the palliative care services had some form of access to pain management. A number of services only had informal access to pain management. Only one service had formally established joint assessment and management of patients with the respective pain service established. 2/3 of palliative care services had referred less than five patients over the last year. Education around interventional pain management was scanty and only two units had written policies regarding management of patients undergoing pain interventions.
Conclusion: Availability of interventional pain management remains patchy and should be improved to guarantee appropriate assessment and access to procedures for all cancer pain patients who require it. Guidelines and protocols need to be developed around formal, joint working and appropriate education for staff.

PE 1.F55

Audit of management of malignant spinal cord compression in an Irish regional hospital

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Introduction: Malignant Spinal Cord Compression (MSCC) occurs in up to 5% of patients who die from cancer. The most important factor determining prognosis is the degree of neurological function at the beginning of therapy.
Aims: To assess compliance with hospital based guidelines regarding management of MSCC.
Methods: Patients with MSCC were identified by consulting with oncology teams and the radiology department. The following information was documented.
1. Patient diagnosis
2. Symptoms and signs
3. Duration of symptoms
4. Steroid dose pre-MRI
5. Waiting time for MRI
6.Was wholespine MRI completed?
7.Time to radiotherapy
8.Outcome.
10 patients (March 07-August 07) were identified with MSCC. The results were audited and our practice was compared to previously identified standards. Implementation of change was undertaken in September 07. Audit cycle was completed Sept 07-Feb 08 to determine if practice had changed.
Results: 4 standards were identified against which our practice was measured. March-Sept 07.
1) 50% pts received steroids pre-MRI.
2) 100% pts had MRI.
3) 80% pts had wholespine MRI.4)10% pts received Radiotherapy (DXR) within 24hrs.
Post implementation of change Sept 07-Feb 08.
1) 50%pts receive steroids pre-MRI.
2) 100% pts had MRI.
3) 100% had wholespine MRI 4)60% pts received DXR within 24hrs.
4 standards were identified against which our practice was measured. 2 standards were achieved. 100% of pts have MRI scanning and 100% of pts have wholespine MRI. Steroid treatment pre-MRI remains below standard at 50%. The % of pts receiving DXR improved in part 2 of the cycle.
Conclusions: Our results remain below standard. To consistently achieve all standards, the education of junior doctors and nursing staff needs to continue. The audit highlighted that surgical doctors and GPs also need to be educated on the management of MSCC. The NICE guidelines will be published in Nov 2008.The hospital guidelines will be re-evaluated at this stage.

PE 1.F56

Audit of medical management of inoperable bowel obstruction in a specialist palliative care unit

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Introduction: Malignant Bowel Obstruction is a common complication in patients with advanced abdominal or pelvic malignancy such as colonic, ovarian or gastric cancer. The frequency of Bowel Obstruction in patients with advanced ovarian cancer ranges from 5% to 42% and in patients with advanced colorectal cancer from 4% to 24%.
Aims: To audit the medical management of patients with malignant bowel obstruction (MBO)admitted to a specialist palliative care unit over a six month period, July 08- Dec 08. The standards against which our current practice will be audited against are based on recommendations by an EAPC expert steering group , 2001.
Methods: Data collected from charts of patients with MBO managed in the unit and information charted as follows:
1. underlying malignancy
2. symptoms of bowel obstruction
3. signs of bowel obstruction
4. radiological evidence
5. Antiemetics- starting dose- range of doses
6. Antisecretory agents-starting dose-range of doses
7. Analgesics- starting dose-range of doses
8. Steroids
9. Laxatives
10. NG tube
11. Duration of management
12. Outcome.
Results: The audit is ongoing. There are 15 cases to date of MBO since July 08.
1) 15/15 patients had a combination of analgesics, antiemetics and antisecretory agents
2) 4/15 patients had nasogastric tubes as temporary measures
3) 0/15 had total parenteral nutrition
4) 4/15 had parenteral hydration.
Conclusion: To date our practice complies with standards that are based on EAPC recommendations. However documentation must improve as to
a) why certain drugs are prescribed
b) why total parenteral nutrition and hydration are not utililised.
c) why the 5 cases that developed MBO following admission did not have a surgical review.
The specialist unit does not have guidelines as to manage MBO and this is an area that will be addressed. The results of this audit will be presented at a multidisciplinary educational session in Jan 09.

PE 1.F57

Opioid rotation practices in a specialist palliative care unit

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Aim: It is well known that patients who develop intolerable adverse effects while achieving suboptimal analgesia may benefit from opioid rotation or switching. Indications for opioid rotation include:
1. poor response to initial opioid (inadequate analgesia)
2. intolerable adverse effects
3. poor compliance
4. renal impairment
5. patient request
6. need for alternative route of administration.
Our aim is to audit opioid rotation practices in a specialist palliative care unit, intervene with educational sessions around the rationale for and documentation of opioid rotation, and review our practices within 3 months.
Methods: Retrospectively review 100 inpatient charts to look at baseline patient demographics as well as
1. baseline opioid (opioid on admission)
2. indications for rotation
3. choice of opioid
4. dose conversion ratio
5. documented response to rotation.
This will be repeated for each opioid rotation per patient as some patients may rotate through a number of opioids during the course of their inpatient stay.
Results: This audit remains a work in progress so complete results are currently unavailable.
Conclusion: Although opioid rotation is a common intervention in specialist palliative care units, our documentation around the indications for rotation are often suboptimal. Dose conversion ratios are often not documented, symptoms of opioid toxicity are often unclear and patient renal function may not be recorded. In the event of patients requiring a further rotation, lack of documentation may hamper decision making. Individual prescribers often use differing conversion ratios depending on their previous experience, all of which combine to make the area of opioid rotation confusing. Staff education and documentation regarding opioid rotation are essential to improve patient outcomes.

PE 1.F59

Does the doctor listen to the consultant palliative care team? An assessment

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Background: The Pain and Palliative Care team (PPCt) work as consultants in an acute care hospital. After assessing a patient we give advice to the doctor in charge, who is free to implement the proposed treatment or not. Our aim was to determine if and how our propositions were followed, and what was the outcome for the patients.
Methods: Prospective observational study. From February 2008 we included 100 consecutive patients referred to the PPCt for uncontrolled pain. The reason why the treatment was not implemented was asked either to the doctor or to the nurse in charge. Propositions followed only in part were recorded.
Results: The PPCt's propositions were implemented for 72 patients (PI group), partially for 16 (PpI group), and not implemented for 12 (PnI group). Most consultations took place in the medical or the surgical wards. The PPCt's advice was equally followed in both divisions. The patients' mean VAS scores were 78 mm (± 22) on the first consultation and 47 mm (± 31) at 48 hours ($p<0.0001$). Pain was controlled in half the patients within 48 hours. Compared to the PnI and PpI groups more patients in the PI group had their pain relieved (63% vs 20%; $p=0.0002$). Mean pain intensity did not differ between the PI group and the other patients at baseline and 48 hours later. Pain in PI patients tended to be less severe at follow-up (VAS 42 vs 58 mm; $p=0.06$). The main reasons for not following advice were disagreement about the patient's assessment (n=4) and an intercurrent medical event (n=3). No reason could be found in three cases. In the PpI group, 8 propositions (50%) related to the introduction or increase of an anti-inflammatory medication, mainly dexamethasone (n=6).
Conclusion: The PPC team's propositions were implemented most of the time. When they were not, anti-inflammatory medication was often involved. Of concern is the less favourable outcome of the patients for whom the propositions were not, or only partially, followed.

PE 1.F60

Changes in the consultation activities in the certified nurse for palliative care in Shimane University Hospital

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Aim: The certified nurse (CN) for palliative care directly respond to consultations from medical staff and residents of the community beside working as a member of the palliative care team in our hospital. The purpose of this study is to assess the activity of CN in consultation work with using the retrospective analysis of those consultations.
Methods: We investigated the characteristics of the consultations, such as background of clients, consulted subjects and care taken by the CN, in the last 3 years. Those data were compared among the four periods ;I(2005.9.-2006.3.),II(2006.4.-2007.3.),III(2007.4.-2008.3.), IV (2008.4.-2008.9.).
Results: The number of consultation and consulted subject were symptom management and mental care, mouth care and skin care, family care in periods I, II, III, and IV, respectively. The ratio of consultation from doctors increased to 50% in period IV from 13% in period I. The ratio of consultation from patients and family increased to 16% in period IV from 24% in period I. The ratio of consultation from another hospitals also increased to 14% in period IV from 3% in period I. The popular subjects consulted were management of physical symptoms, and management of psychological symptoms, skin/oral care, and family care were followed. In physical symptoms, consultation for swelling increased to 78.4% in period IV from 42.4% in period I. The CN assessed their swelling and performed relaxation, lymphedema management,and supports in staff nurses practice.
Conclusions: The present results suggested that the role of CN has been well recognized by patients and family as well as medical staff, and they became to use the CN for palliative care properly.

PE 1.F61

The experience of seven years of domiciliary palliative care from 2000 to 2007

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In Italy the Domiciliary Palliative Care is included in the Essential Levels of Assistance (L.E.A.) and free insured by the National Sanitary System (S.S.N.). In the territory of the USL 6 the predictable use for the Domiciliary Palliative is at least 1.500 new cases per year. Palliative Care can be activated by an application of the Family Physician (M.M.G.) or by an Hospital indication (Programmed Dimission). Multi Dimensional valutation takeplace at home or in hospital by the Palliative Valutation Unit (UVP) that fill a personalzed Assistance Plan based on the needs of the patient and its familY.Purpose of the study: to observe the assistance evolution during the years to draw indications about budgeting and audit assistance's quality. Revision of all the palliative domiciliary care from 2000 to 2007 is made (MA=midle access):
New ass.: 268-476-654-768-822-700-923
In load/potential: 17,9%-31,7%-43,6%-51,2%-54,8%-46,7%-61,5%
Midle days: 36,6-38,2-45,7-41,7-426-44,4-45,3
MA Physician: 10,1-10,1-11,2-10,7-10,1-9,1-9,8
MA Nurse: 11,9-11,0-13,3-12,9-12,1-12,0-12,5
MA Ftk: 3,7-2,6 -3,0 -2,9 -2,9-2,1-2,2
MA Soc.Ass.:1,9-1,3-1,2-1,3-1,4-1,6-1,5
M A Psychologist: 1,2-1,0-1,1-1,0-1,1-1,0-1,2
MA CIA: 0,78-0,68-0,65-0,69-0,65-0,58-0,60 ybr<y %
hospital refuge: 2,19%-2,51%-2,09%-3,79%-3,77%-3,87%-5,06%.
The relationship between physician's and nurse's accesses is grown in favour of the nurses; this is due from a side to a more efficacy of therapy against the pain, and on the other side, to the assumption of cases more complex (CVC, Port a cath, Nutritional Support), that are nurse's competence.The days of refuge in hospital have had an increase because of the consolidating use of palliative radio-chemotherapy protocols and an higher incidence of "long survival" complex assistances.The introduction of the new figures of social support has shown, in the preliminary audits, a notable increase of the perceived Quality of Life (Q.of L.), for the patient and his family.

PE 1.F62

Implementation of the Liverpool Care Pathway (LCP) in a teaching hospital in Switzerland: A story of success

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Rational: Decision making at the end of life and the care during the dying phase are often characterized by major communication problems and "fights" between the medical and nursing staff leading to distress in patients and families. The LCP has demonstrated to be an effective tool this situation. LCP was translated into german and implemented as part of a quality project within the hospital´s accreditation process.
Method: The 10 step approach as provided by Liverpool thas been followed and "multiplicators" have been appointed each in nursing and medical staff in all departments. Extensive education and on-site counselling was offered through a interprofessional project team providing 24-hours on call service. Outcomes were evaluated according to the pathway's goals, and international benchmarking with the UK-audit on LCP in the hospitals was performed.
Results: After an initial pilot phase in 6 different units and 18 months of clinical implementation in all departments and hospitals (1024 beds) the LCP evaluation as part of the hospital audit showed best dissemination throughout the hospital and got best rating (D) in regard of the accreditation procedure. Around 27% of all dying patients entered the pathway (n= 159 out of 529 deaths, UK benchmark max. 30%).

Highest performance was achieved in prescribing PRN medication for distressing symptoms (pain, delirium, dyspnoea, nausea, in 92%, 86%, 90%, 88% resp., all higher rates than in UK), and major improvement compared to the pre- LCP period could be stated for discontinuing unnecessary medication and change to the subcutaneous or IV application (90%, 95% resp.).
Conclusions: LCP can be implemented effectively even in a big teaching hospital in Switzerland, and international benchmarking to the results of the UK hospital audit on LCP may be unique in the hospital quality development process.

PE 1.F63

Health care use and expenses at the end of life: Do we care?

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Aim: It is well known that the cost of health care generally peaks at the end of life. We aimed to investigate care trajectories, health care use, and related community expenditure during the last six months before death.
Methods: The study population contained 40965 persons (age > 40), who died within one year (July 2005-July 2006). In Belgium, sickness funds are in charge of the management of the compulsory health insurance. Therefore, health care use was inferred from reimbursement claims, including information on diagnostic and therapeutic procedures, institutional and home care, and reimbursed drugs. Specific hypotheses were tested using logistic and nominal regressions, and analysis of variance.
Results: The most common pathway (19.5%) was where people were staying at home but were dying in the hospital. 42.1% of the persons who died in the hospital (49.6% of the population) were transferred during the last week before death.
From the total population, 18.5% could be identified as having received palliative care (palliative population). The health care use and expenditure differed between the palliative and non-palliative population. The probability of getting palliative care was mainly dependent on a combination of age and cancer (being a cancer patient or not). The total community expenditure per person was highly dependent on age, presence of cancer, and place of death. 53.3% of the palliative population died at home, where the community expenses (median) per day are ten times smaller as compared to the palliative service in a hospital. However, it has been shown that the personal cost of care for the patient and their family is much higher at home. Additionally, other factors determine whether one can stay and die at home or not. In this regard, reference will be made to a qualitative study by means of 10 focus groups.
Conclusion: To conclude, recommendations for policymakers will be distilled from this research.
(No external funding)

PE 1.F64

Early detection of bone metastasis by 11C-Choline-PET/CT: A feasibility study in patients with prostate cancer

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Aim: The prognosis of patients (pts.) with less than 5 metastasis (mets) is significantly better than in pts. suffering from multiple mets (Singh, 2004). Therefore early detection of bone mets might be useful. We compared the feasibility of 11C-Choline-PET/CT (CPC) for the detection of bone metastasis (BM) to bone scan (BS) and 18F-Fluorid-PET (F-18 PET). CT imagines acquired during PET/CT were used as reference.
Methods: In 86 pts. CPC`s covering neck to prox.femora were performed and compared to the results of BS and/or F-18 PET. The 3-D volume of BM and the focal C-11 choline uptake (SUV) was measured and the visibility of BM in CPC was compared to CT, BS and F-18 by four experienced readers. Results of CPC were compared with clinical data (antiandrogenic therapy (AD), age,TNM-class., PSA at the time of diagnosis (iPSA)).
Results: 86 pts. were divided in two groups: Group I (n=47) comprised pts. with < 5 BM: mean age 66.5 ys., PSA 35.5 ng/ml, PSA(CPC) 13.2 ng/ml, time between initial treatment and CPC 33.5 mos., 36% received AD. Group II (n=39) comprised pts. with > 5 BM: mean age 66.8 ys., iPSA 45.4 ng/ml, PSA(CPC) 28.5 ng/ml, time between initial treatment/CPC 67 mos., 69% received AD. TNM-status was similar in both groups. The osteoblastic BM of pts. not receiving AD had a SUVmean of 3.68 and SUVmax of 3.81. In contrast, pts. who underwent AD showed a SUVmean of 4.04 and SUVmax of 4.49. No correlation between BM-volume and 11C-choline uptake was found. In 55%(47/86) additional information about tumor progression (LR,Lnn.) was provided by CPC. The number and kind of detected BM in CPC was higher compared to BS resp. F-18-PET.
Conclusions: These preliminary data indicate that in pts. with prostate-cancer 11C-Choline-PET/CT is on significance compared to BS and F-18 PET. Additionally this method detects neither bone mets nor local recurrence and/or lymph node involvement.

PE 1.F65

[11C]-choline PET/CT imaging for Restaging of prostate cancer patients with biochemical relapse after low-dose rate brachytherapy

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Aim: Impact of [11C]choline positron-emission tomography (PET)/computed tomography (CT) imaging for Restaging in prostate cancer (PCA) patients with biochemical relapse after low-dose rate brachytherapy (LDR-B).
Methods: 169 patients with localized prostate cancer and low-risk of relapse were treated by LDR-Brachytherapy with 125J-seeds. Biochemical relapse was defined according to the ASTRO criteria. All patients with relapse underwent transrectal ultrasound (TRUS), digital rectal examination and [11C]choline PET/CT imaging. None of the patients was under hormonal therapy when PET/CT was performed. In patients with potentially curative intent to treat the suspected area in PET/CT imaging was biopsied.
Results: Nineteen patients experienced biochemical relapse with a prostate-specific antigen (PSA) after LDR-B during a folow-up period of 48.5 months. Eighteen patients had a positive PET/CT showing local recurrence (11), local recurrence and regional lymph node metastasis (3), local recurrence and bone metastasis (1) or no local recurrence but regional lymph node metastasis, bone metastsis or pulmonary metastasis (3). Only in one patient a focal inflammation was seen. All patients with solitary local recurrence underwent prostate biopsy which affirmed the diagnosis of reccurent PCA in all cases. The PET/CT findings had a potential impact on the appropriate individualized therapy with a proportion of patients receiving salvage radical prostatectomy (2/19), external beam radiation therapy (2/19), chemotherapy (1/19), hormonal therapy (2/19) and watchful waiting (12/19).
Conclusions: [11C]choline PET/CT is a exellent examination for re-staging of prostate cancer patients after LDR-B with rising PSA values, allowing to discriminate patients with local recurrence from patients with distant metastasis with a potential impact on the consecutive therapy.

PE 1.F66

Can patient characteristics predict serum concentrations and the ratio between oxycodone, noroxycodone and oxymorphone? A multicentre cross-sectional study

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Oxycodone (OX) is a frequently prescribed opioid in palliative care in Europe. However, OX is far less studied than morphine. Studies of patients on OX and its major metabolites are few and the series are small. As a part of the European Pharmacogenetic study (EPOS) we aimed to study the relationship between clinical characteristics and serum concentrations of OX and its metabolites after oral administration in cancer patients. Of 2300 patients included in EPOS, 421 (237 men and 184 women) were using oral OX. Clinical and laboratory data and blood-samples for DNA and opioid serum concentration analysis were collected. OX, noroxycodone (NOROX), oxymorphone (OXYM) and noroxymorphone (NOROXYM) were analysed by mass spectrometry. Patient characteristics (median (min-max)): Age 63.2 (18.9-91.2) yrs, BMI (body mass index) 23.5 (14.3-41.2), Karnofsky status 70 (20-90)%, time since cancer diagnosis 19.5 (0.2-291) months. OX dose was 60 (10-1600) mg 24 h-1. Serum conc. (nM) was OX 97 (0-1890), NOROX 101 (0-4865), OXYM 1.4 (0-27), NOROXYM 16.4 (0-509). Ratios were NOROX/OX 1.1 (0.1-24) and OXYM/OX: 0.02 (0.01-5).The effect of patient variables (gender, age, BMI, time since diagnosis, Karnofsky, number of medications other than opioids taken last 24 h daily dose, creatinine and albumin concentrations on serum conc. and ratios was explored by backward stepwise linear regression. Totally daily dose was associated with serum conc. of all compounds and both ratios. Gender was associated with NOROX/OX ratio. BMI and albumin was associated with OX conc. and NOROX/OX ratio, while age and creatinine was associated with NOROX/OX ratio only. Number of medications taken last 24 h was associated with ratio of OXYM/OX. As expected daily dose was the most prominent predictor of OX and metabolite cons. and ratios. BMI and albumin affected OX cons. Note that all association factors (except number of other medications) affected NOROX/OX ratio, which is heavily dependent on CYP3A4 activity.

PE 1.F67

Effects of opioids on cellular immunity: Importance for supportive and palliative care

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Opioids are often the mainstay of analgesic therapy for severe pain. They are also commonly used as part of drug rehabilitation programmes. Some patients on these medications for either of these indications may have cancer or infection, including HIV.
The immune system is critical in the control of both cancer and infection, including HIV. Some opioids, through both central and peripheral mechanisms affect immune function. Other opioids have little or no known effect on immune function. In clinical practice this side effect may be overlooked potentially compromising the care of patients with cancer or infection.
Current evidence from clinical studies suggests that morphine and methadone are predominantly immunosuppressive. Buprenorphine and oxycodone appear immuno-neutral. Fentanyl has been shown to increase natural killer cell activity in human studies despite appearing immunosuppressive in in vitro studies. Tramadol has repeatedly been shown to enhance NKCC and this is thought to be due to its serotonin reuptake inhibition. In animal models Tramadol reduces the risk of metastasis and has also been shown to preserve immune function in patients undergoing surgery.
Studies in macaques infected with SIV indicate that morphine causes a higher viral load and increases the likelihood of death.
Although studies have shown that Methadone enhances HIV infection by up-regulating the expression of T cell receptors, a recent study in heroin users has shown that both Buprenorphine and Methadone

preserve immune function compared with heroin use. The immunomodulatory actions of individual opioids may therefore need to be considered as part of the therapeutic decision-making process in managing pain and addiction especially when there is coexistent cancer or infection, such as HIV.
Funding for this project was provided by the local University.

PE 1.F68

Impact of therapy with octreotide and butylscopolamine on frequency of emesis in malignant bowel obstruction

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Introduction: Octreotide, a synthetic somatostatin analogue, reduces the secretion of gastric acid, enzymes of the exocrine pancreas and lowers the motility of the upper gastrointestinal tract. Thus it is an effective therapy in addition to butylscopolamine in the conservative therapy of malignant bowel obstruction (MBO). Here we report on a single center experience with octreotide and butylscopolamine in the treatment of MBO.
Patients and methods: From 330 patients admitted to the Palliative Care Unit between 8/2007 and 10/2008 eight patients have been treated with octreotide and butylscopolamine and were included in this retrospective analysis.
The frequency of vomiting in patients with MBO before and during the first 9 days of therapy with octreotide and butylscopolamine was investigated.
Results: The mean dosage of subcutaneously administered octreotide was 300 µg per day (range 150-1500 µg per day). The mean dose of butylscopolamine administered subcutaneously or intravenously, was 45 mg per day (range 0-80 mg per day). At the day prior to initiation of therapy with octreotide and butylscopolamine the mean frequency of vomitings was 4.4 per day. During combination treatment with both drugs, the mean daily frequency of vomitings was reduced to 1.4 on day 4 and to 0.5 on day 9.
Conclusion: Within the observed small group of eight patients the combination of octreotide and butylscopolamine was highly effective in symptomatic treatment of patients with MBO. In the present study, this treatment regimen reduced the daily frequency of vomitings by 89 % within 9 days.
Further prospective studies will be necessary to evaluate the definitive efficacy of octreotide.

PE 1.F69

C-reactive protein as a prognosis indicator in solid tumors: A systematic review

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Aims: In the last decades, studies showed correlations between inflammation and cancer. Serum C-reactive protein (CRP) levels were linked to prognosis and survival in malignancy. We systematically searched available literature to answer: In patients with solid malignancies, to what extent does serum level of CRP predicts prognosis and survival?
Methods: MeSH terms were used [(prognosis OR treatment outcomes OR Survival) AND (C-reactive protein OR CRP) AND (cancer OR Neoplasms)] to search the following electronic databases: PubMed, EMBASE, Web of Science, SCOPUS, EBM-Cochrane Central Register of Controlled trials and EBM-Cochrane Database of Systematic Reviews, and Biological abstracts/Biosis previews. This search included all publications until 2007.
Inclusion criteria: English articles only; studies (all study designs) of solid malignancies in adult population; prognostic studies with CRP measurement. Letters and comments type of publications were excluded.
Quality assessment of studies: A quality assessment (QA) scoring system was developed based on existing guidelines for observational cohort prognostic studies. It combines 5 criteria: study design, patient selection, prognostic variables, follow-up, and data analysis. Total score was expressed as percent of maximum score. Studies that scored <50% were considered as an inadequate and were excluded.
Results: 104 out of 168 articles were included in this preliminary analysis. 80 studies had a prospective longitudinal design (only 12 with control group). 76 studies found CRP to predict prognosis. Positive studies by tumor type: colorectal (16/21), renal cell carcinoma (16/21), gastrointestinal (12/14), lung (7/9), pancreas (6/8), melanoma (5/5), breast (3/5), prostate (1/3).
Conclusion: CRP is valuable as predictor of survival and treatment outcomes in various tumor types.

PE 1.F70

From interviews to a nation-wide study on siblings having lost a brother or sister to cancer

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Little is known about the long-term psycho-social consequences for siblings experiencing the suffering and loss of a brother or sister to cancer. The objective was to find a suitable study design and cohort to investigate the long-term outcome of bereaved siblings in relation to different healthcare factors pertaining to the brother or sister's illness and subsequent death. A questionnaire was developed after in-depth interviews with 8 bereaved siblings. The questionnaire was tested through face-to-face validations with another 8 bereaved siblings. Next, two pilot studies were done to assess best logistic approach and response rate in attempts to identify the most suitable cohort for a nation-wide study in Sweden. The first pilot study included siblings who had lost a brother or sister to cancer 4 to 17 years ago; 15 out of 29 (55%) responded. The other pilot study included siblings who had experienced the loss 2 to 7 years ago: 15 out of 17 (88%) responded. A control group of non-bereaved siblings received a similar but smaller questionnaire on psycho-social issues. In this group two logistic approaches, i.e. preceding phone contact or not, were tested. The response rate among those first contacted by phone was 83%, (n=19/23) as compared to 50% (n=25/50) among those not contacted. The results suggest that for a nation-wide study on bereaved siblings based on a postal questionnaire, an acceptable, participation rate is difficult to obtain more than 7 years following the loss. Moreover, the postal questionnaire should be preceded by a personal phone call as it seems to promote participation. Before initiating the nation-wide study, it remains to analyse the compliance with the questionnaire, the results of which may prompt modifications of some questions.

PE 1.F71

Bereavement support - A pilot project in rural Australia

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Background: Subsequent to research attended in the above setting in regards the effectiveness of existing bereavement support provided by Community Cancer Care Team (CCCT) (presented in poster format EAPC Venice 2006) it was found both inclusive in the research and external anecdotal evidence compiled by Tweed Palliative Support (TPS Volunteers) that a component of the bereaved community would value the provision of formal bereavement support. Following this the researchers reviewed existing bereavement support programmes in the UK, Europe and Australia, adapted and developed a programme thought to be suitable for the rural Australian population. Additionally, TPS wrote a successful submission to fund a programme and made their venue available to conduct the programme, transport was also offered to intending participants.
Overview: Letters of invitation to attend are included in the bereavement support card sent to families by CCCT six weeks post bereavement. The qualitative study reviews the evaluations of each of the five sessions of the programme conducted on five separate occasions in the past year.
Setting: The programme was conducted in a large family home which is currently the premises occupied by the TPS. The building is set in semi tropical bushland.
Outcome: Five programmes were conducted by two facilitators over a five week period Participant numbers varied from three to seven.
Results: Overwhelming satisfaction as demonstrated in the body of this study included 100% recognition of the importance of being able to share feelings and experiences in a safe and nurturing environment. Further to this participants recorded that it was helpful to know that there is no set pattern for grief and that they felt better equipped to cope following the programme.
Conclusion: Due to the positive response by participants and increasing interest expressed by professional organisations TPS has applied for further funding to continue this programme.

PE 1.F72

The voices of experience: An interpretative phenomenological analysis of parental accounts allied to the quality of life following adult child death

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The focus of this study was designed to explore the self reported experiences of subjective wellbeing and quality of life within bereaved parents, following the death of their adult child. This project has sought to interlink the parents' own thoughts, feelings and experience of bereavement, and the subsequent coping mechanisms they have adopted during their daily lives. This research design utilised a qualitative methodology, and deployed an idiographic approach, which incorporated interpretative phenomenological analysis (IPA) coupled with a semi-structured interview process; to capture the parent's own perspective of such a phenomenon within this culturally sensitive domain. A homogenous sample of bereaved parents was recruited, to gain an understanding of this human experience. These subsequent parental accounts, relating to the experience of adult child death upon parental quality of life clustered around five main super-ordinate themes, namely:
(i) Emotional Buffers associated with Parental Wellbeing;
(ii) Evaluation of the Impact of Death;
(iii) Effects of Bereavement;
(iv) Subjective Acceptance to Life Adjustment and
(v) Social Support.
Leading to the conclusion, that one's subjective well-being, following the demise of an adult child, required the parent to find a place for the deceased child, which enabled the parent to remain, connected to the deceased; but in a manner that did not preclude them from getting on with their own life. However, these accounts indicated a very slow reduction of parental distress even after the passage of time. Yet, all the parental accounts reflected upon the benefit of socially sharing their emotions with others. Moreover, this study revealed, the health care management of bereavement was in need of profound modification; which necessitated a greater emphasis upon the levels of professional intervention that focused upon talking therapies. This research was a self-funded project undertaken by the authors.

PE 1.F73

Distress in bereaved caregivers

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Aim: The objective of this study was to investigate the impact of the bereavement reaction in caregivers to deceased patients treated in a specialist palliative care team. The study aimed to identify caregivers in distress up until $1^{1/2}$ years after the loss. The study group was compared to a non-matched group of bereaved persons not receiving palliative care to compare their level of distress.
Methods and design: Adult caregivers to deceased patients were asked to participate in a longitudinal study one month after their loss and until 18 months post loss. Included in the study were 87 bereaved caregivers: 60 females, 27 males. At 18-months follow-up, 59 participated. Mean age: 53 years. The majority of the participants had lost a spouse. A bereaved non-matched segment of the population in the same geographical area served as a comparison group: N=296; Mean age: 73 years. The participants were asked to complete a self-report questionnaire measuring complicated grief (ICG-r), depression (BDI) and PTSD (HTQ) at 1, 6, 13 and 18 months post loss.
Results: At 18 months follow-up, 24% of the bereaved caregivers were still in distress, meeting criteria for either complicated grief, depression and/or PTSD. 7% of the bereaved caregivers met the criteria for all three

diagnoses. In the comparison group, 22% showed distress - meeting the criteria for one disorder while none met criteria for all three diagnoses.
Conclusions: This study indicates, that ? of bereaved caregivers are still in distress 1? years after the loss. Compared to a non-matched bereaved population not receiving palliative care, the bereaved caregivers seem to experience more extreme distress following bereavement. The results of this study raises the questions whether bereaved caregivers receiving palliative care generally experience more extreme distress and/or targeted bereavement support is insufficient in palliative care.

PE 1.F74

Support groups for bereaved young adults, aged 18-30 years

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Background: A program aimed at improving support for relatives,and particularly relatives at risk for complicated grief, has been implemented at the Palliative section, Stockholms sjukhem Foundation. One specific intervention offered in the program is the support group for bereaved young adults who during the previous six months have lost a parent or a sibling.
Aim: To offer support and bereavement management within the frame of a group of young people, aged 18-30 years, in order to facilitate grief recovery and to prevent future complications.
Method: The bereaved young adult is invited to a support group, 1-6 months after the loss. The support group meets during ten weeks, once weekly during two hours. Frames are: the place - a nice lounge located at a distance from the hospital, the session-two hours, weekly, refreshments are served and finally- a ritual to open the session-every participant lights a candle in a glassbowl with water; a symbol of the deceased. The group session themes emerge from the participants feelings and thoughts, the tool is the process of the group; the participants listening to, sharing and helping each other, rather than interventions of the leaders. Themes can be identified, similar in all groups, such as: memories (from illness and death, but also from childhood and family),anger and guilt, responsibility, death and continuing bonds, support and comfort and finally the future(fear and hope).
Results: The group evaluations show that the support given in the groups is much appreciated and helpful to the young adults. Meeting others of the same age, sharing the same experience is the best way to normalize and cope with feelings of pain and loneliness.
Conclusions: Support groups for young adults are a helpful tool to facilitate the grieving process and to prevent illbeing in the future. Young adults are a vulnerable group and when someone significant to them has died, they benefit substantially from the experiences and support of others in a similar situation.

PE 1.F75

Teenagers loosing a parent to cancer - Risk factors causing long term morbidity

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Background: Some bereaved individuals suffer health consequences that lasts years after the loss. Bereavement literature, including all causes of death, suggests that this loss-related morbidity may be caused by specific risk factors from within the intrapersonal and interpersonal sphere as well as the nature of death. There are several studies of adults bereaved by cancer. Research findings suggests that beyond loss itself, bereaved adults have been subjected to additional trauma, often related to treatment and care, that increases the risk for long term psychological distress. It is not known whether these health care related factors have lasting negative effect also on bereaved youths.
Aim: The aim of this study is to find out if bereaved teenagers suffer long term psychological distress and if this is determined by health care related factors.
Methods: A study specific questionnaire has been developed based on 16 semi structured interviews and face-to-face validation sessions with bereaved teenagers and on relevant literature. Items are constructed around communication, perceptions and experiences of treatment and care, including symptom management and mode of death, social support, family cohesion, and grief reactions. Outcome variables include anxiety, depression, sleeping difficulties, self harm, drug and alcohol abuse and academic achievement. Our goal is to include 1 000 teenagers bereaved of a parent between the years 2000 and 2003 in a nationwide study in Sweden. An additional 500 non-bereaved and randomly selected peers will also be included. Data collection is scheduled to 2009. Data will be analysed by epidemiological methods.
Implications: Findings may be used to prevent unnecessary suffering and long term negative psychological effects in bereaved teenagers.

PE 1.F76

A bereavement service for children and adolescents run by a charity. Development of a special programme for bereaved boys since 2005 - www.allesistanders.de

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The hospice movement in the German university city of Freiburg (Hospizgruppe Freiburg e. V.) established itself as a charity of volunteers in 1991 looking after terminally ill patients and their families. Since August 2003 a bereavement service for children and adolescents with an internet platform was developed.
Aims: We started to offer mourning groups for various ages and discovered that bereaved boys did not like to participate spontaneously in a group. Therefore we tried to reach them through specialy designed offers for them.
Methods: With the financial support of «Aktion Mensch» we could finance a half time social worker's post for 3 years until October 2008 to help the volunteers to have a more structered support. There were developed groups for children (5-8 years), art therapy (5-17 y), working with wood (11-16 y), climbing (6-18 y), home visits. In addition liaising with and counseling of other support organisations was initiated, public relations improved as fundraising done through various activities.
Results: The highest numerical impact has our internet platform with 30 daily visits. A third of the visitors are boys. The children's groups run on a weekly basis up to 11 sessions. Art therapy encompasses graffiti (once off) and accompanied painting. The carving of wood is limited to 4 boys for security and supervision reasons. In the climibing group are 6-9 boys. In all these activities boys tend to start to talk to each other while doing things. This is in complete opposition to girls who can sit down in a group and speak to each other. Home visits were organised for 4 boys while the singel mother was dying of cancer.
Conclusion: The expression of emotions and feelings is essential in a bereavement process. Boys need a more practical way of expressing themselves. If they are denied of an appropriate expression they are at risk of not finding a new sense and meaning in their life through the loss of a loved one.

PE 1.F77

Hospital nurses understanding of the palliative care needs of patients with learning disabilities: A survey questionnaire

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Since the closure of long stay institutions people with Learning Disabilities (LD) access mainstream health services. People with LD are living longer and more likely to develop age-related illnesses such as cancer, thus, requiring Palliative Care (PC) services.
Aims: To assess the skills and confidence of hospital nurses in addressing the Palliative Care needs of patients with LD.
Method: A survey questionnaire was designed and distributed to a sample of 109 senior nurses, and Palliative Care Network nurses (ward based link nurses) in a large acute teaching hospital. The dimensions examined included various aspects of holistic care for this patient group, including awareness of tools / policies / other care agencies that may aid assessment / care. The study also examines recognition of dying, and confidence in provision of end of life care. Dimensions were recorded on a likert scale where 1= strongly agree to 5= strongly disagree, with free text for individual responses.
Results: Initial results reveal a higher level of confidence than anticipated in provision of various aspects of care (both general and end of life care) by generic nurses with no LD training. Full data will be available on evaluation of questionnaires.
Conclusions: The questionnaire has highlighted areas of educational need (as identified by respondents) which can be addressed through collaboration with local /regional LD networks. Staff information leaflets, training sessions, and formal certified courses were identified as helpful resources to meet educational requirements.

PE 1.F78

Psycho-existential training for health care workers - Does this improve patient care and reduce burnout?

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Aims: Quality end of life care can be affected by the health care workers´ own fears of life and death, which can interfere in their helping relationship with the patient and family. This can lead to increased levels of burnout. This research aims to evaluate the effects of a course which would address these issues within a therapeutic setting.
Method: The course consisted of 6 days group therapy with a maximum of 10 participants per group. 150 health care workers who work with dying patients, in and out of palliative care units, filled in questionnaires, which have been evaluated in Portugal, to assess their level of personal well being, burnout, and the quality of their helping relationship before and four months or over after the training. Qualitative interviews were carried out with 26 participants.
Results: The results revealed a significant improvement in the health care workers´ skills in the helping relationship, (unconditional acceptance, positive regard, empathy and congruence) a significant reduction in levels of burnout (decrease in emotional exhaustion and depersonalization and increase in sense of professional fulfillment), and a significant reduction facing fears of life and death (pain, loss of dignity and physical degradation, lack of meaning in life and close relationships with loved ones). There was also a positive correlation between reduction in fears and levels of burnout, reduction in fears and quality of helping relationship and reduction in burnout and quality of helping relationship.
Conclusion: This study shows that education with personal development in palliative care may be effective in addressing the health care professional's personal fears regarding life and death, in order to enable them to effectively care for the dying without avoiding a meaningful helping relationship with the patient and without suffering from burnout in their working environment.
This research was funded by the Calouste Gulbenkian Foundation.

PE 1.F79

Development of service learning in an end-of-life setting; An interpretive descriptive study

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Palliative care education and experience at the beginning of the nursing curriculum, although challenging, is worthwhile as it helps prevent students from developing false ideas and assumptions about care of the dying (Mallory, 2003). With an aging population and concurrent prevalence of chronic disease, the demand for end-of-life care will increase considerably in the near future (Canadian Hospice Palliative Care Association, 2007). Therefore, preparing nurses to provide excellence in end-of-life care is essential.
By attending to those who are dying, nurses have a unique opportunity to be present during poignant moments in both patient´s and their family´s lives. Providing end-of-life care early on in the early part of the nursing baccalaureate program is a facet that thus far has not been implemented at Thompson Rivers University. In doing so, this gives students a chance to look at core services (Health Canada) and for the service partner, there are opportunities for recruitment and retention.
The proposed interpretive descriptive study will allow for an opportunity to build bridges between Thompson Rivers University and community service partners

while at the same time offering a more formal palliative educational component as part of the nursing curriculum thus receiving a better rounded learning experience.
This project will promote nursing student education as well as provide support to under serviced community partners who specialize in providing palliative care to members of the Kamloops community in British Columbia, Canada.
The aim of the research is to further understand the learning that student´s experience early on in their bacclaureate education. Interpretive descriptive methology will be utilzed in November and Deceember 2008 through focus group discussions.

PE 1.F80

Advance care planning in a large tertiary hospital: Results of a hospital-wide intervention

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Aim: The aim of the study was to observe if a hospital-wide intervention could change pro-active EOL (end-of-life) behaviour of physicians on the hospital wards.
Methods: The study was performed in the Ghent University Hospital, a tertiary hospital of 1062 beds. The intervention consisted in
1) informing hospital staff on the Belgian laws on Patient's Rights and Palliative Care and
2) introduction of a new DNR form.
Data concerning EOL decisions and documentation on the written DNR form were collected before and after the intervention. EOL decisions in all adult patients who deceased during a 12-week period in 2007 and a 16-week period in 2008 and who were admitted at least 2 days on a non-ICU ward in their final hospitalisation (in whom it was possible to address EOL issues) were studied.
Results: In table 1, a summary of all quality indicators are listed. No significant differences were observed between both periods. However, improvement in filling-in the written DNR form was observed: physicians significantly more frequently noted down who participated in the DNR decision (for participation of family: 44% vs. 63% (p=0.022), for nurses: 14% vs. 27% (p=0.047)) and why the DNR decision was installed (32% vs. 59%(p= 0.001).

All deaths Patients dying on non-ICU No DNR Patients dying with DNR form Dying on ICU ICU stay last episode Dying without DNR form DNR code 0 (full therapy) or 1 (no CPR only) First DNR within 48 h before death Information patient reported by physician Information patient reported on DNR form Participation nurse (involved) Pre- intervention (n=115) 23% 37% 8% 4% 4% 91% 25% 61% Post-intervention (n=113) 22% 40% 13% 5% 8% 89% 40% 57% p= 0.731 0.629 0.332 0.690 0.493 0.390 0.064 0.787
Conclusion: Physicians better filled-in the written DNR forms after being informed about theoretical backgrounds of the new DNR form. However, the intervention had no impact on the pro-active EOL behaviour of physicians measured by predefined quality indicators.

PE 1.F81

Using an innovative educational programme to enhance end of life care in residential care homes

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Current UK government initiatives highlight the requirement for improved standards of care for those at the end of life. A central tenet is that people should be able to make choices about care at this time, including being able to decide where to die. Care homes are playing an increasingly important role in providing end of life care, in particular residential homes. With this in mind an established hospice education centre developed an innovative educational programme aimed at residential care home staff in twenty homes who have not been as visible as their nursing home colleagues in accessing training in this field.
The overall aim of the project was to develop, implement and evaluate a practice development programme for the residential care workforce that enhanced their resident's end of life care experiences. The programme adopts a range of teaching and learning approaches to help maximise learning and assist in application of theory to practice for participants. Alongside study days and a workbook, another key aspect is facilitation by one of the hospice educators in each home to help support learning and sustainable developments in practice within each participating home.
Given the distinct nature of the approach and the staff group involved it was felt important to measure the impact of the programme on individual participant's level of knowledge and on end of life care in the homes through a formal research evaluation. This educational approach is therefore being evaluated through the use of a pre and post education palliative care quiz and two focus groups with programme participants. Although there is some evidence of the impact of the programme on individuals and residential homes, all research data will be analysed by December 2008 with clear findings detailed.

PE 1.F82

Connecting European universities: An experience of higher education strengthening in palliative care, through TEMPUS PROGRAMME, founded by European Commission, in collaboration with the no-profit Italian foundation, Fondiaria-SAI

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TEMPUS PROGRAMME is aimed to strengthen the higher education institutions within Europe in all University Disciplines. The University of Firenze developed the specific project Palliative and Pain Medicine Project (PPMP), aimed to increase the know-how of Palliative Care within University as well as strengthening the colleagues already working in this field or interested to became palliativist. We want to share the complete circle of our biannual project, implemented since September 2007. It is a fruit of a close collaboration among Universities of different countries, with different levels of academic training postgraduate offer in Palliative Care. University of Firenze will present the planning phase worked joint with the Fondiaria SAI foundation, in order to identify other University partners: Universities of Lyon, Beograd and Zagreb. How we have defined the contents and method of Pain and Palliative Care. The implementation phase in Serbia and Croatia: selection of participants and the local training, ended in June 2008 (followed by about 150 attendants). Hence the internships of 30 participants in Firenze, in Crema and in Lyon. The E-learning follow up and the communication strategies implemented. In conclusion we will present the lessons learned by overcame obstacles, the weakness, the participants' evaluation, the outputs and future perspectives.
http://www.palliative4pain.org

PE 1.F83

Views, experiences and educational needs of community nurses about advance care planning

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Background: Advance care planning is a means of setting on record views or wishes about care of patients who may lose capacity in the future. Health professionals are encouraged to implement ACP in their practice as part of the new End of Life Strategy for England. Little is known about their experiences with ACP.
Aim: To examine how community nurses working in palliative care view their roles in ACP, what barriers they perceive and what their educational needs are.
Method: We used an action research strategy, emphasizing practical knowledge to effect change in practice. We recruited 23 community nurses with diverse roles in palliative care from two cancer networks in England. The nurses took part in 6 focus group discussions and three follow up workshops. Data was analysed using a framework approach.
Findings: Most nurses had little detailed knowledge of ACP. They perceived a policy focus on instructional directives (living wills) which was of little relevance to the concerns of their patients. They perceived a series of barriers to ACP: resources; training and education; relationships with colleagues/ patients' families; concerns about patients' reactions. They recommended the following should be included in any education programme: design of 'real' scenarios for training; design of a flow chart; practical advice about communication and documentation.
Conclusion: Nurses working in the community are at the forefront of working with patients with palliative care needs who may wish to set on record their views about future care and treatment. This study reveals some important areas for practice and educational development to enhance nurses' use and understanding of ACP.
Funding: Burdett Trust for Nursing.

PE 1.F84

Current status of physicians in Austria having a diploma in palliative medicine

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Aims: After a two year planning phase between the responsible members of the Austrian Society for Palliative Care and the Austrian Medical Association, a special diploma for Palliative Medicine was implemented in November 2002 as a form of subspecialisation. In order to receive this diploma, physicians are required to attend at least sixty hours of education in palliative care, either taking part in an interdisciplinary or a monodisciplinary course. We are interested in the fact, how many Austrian physicians have a diploma in Palliative Medicine, and also to find out if there are any differences within the nine provinces in Austria.
Methods: Data were collected from the statistics of the Austrian Medical Association. In the evaluation we specified between general practitioners and consultants. In our statistics we compared the various provinces in Austria including the relationship between the numbers of inhabitants to the number of physicians who have been awarded a diploma in Palliative Medicine.
Results: The evaluation between 2002 and 2008 shows that from a total of 1484 physicians who have received a diploma for Palliative Medicine in Austria, 57% were general practitioners and 43% were consultants, most of them for internal medicine (50%), neurologists/psychiatrists (19%) and anaesthetists (12%). Compared with the number of inhabitants Salzburg has the most physicians with a diploma in Palliative Medicine, at the bottom end of the statistics is Styria. Nearly five percent of all Austrian physicians (31.564) achieved a diploma in Palliative Medicine.
Conclusion: This study indicates that since 2002 1484 Austrian physicians have received a diploma for Palliative Medicine awarded by the Austrian Medical Association. We found regional differences between the nine provinces. Implementing a diploma for Palliative Medicine was an important first step in integrating basic knowledge regarding palliative care into the postgraduate training for physicians.

PE 1.F85

Working together: Challenges and opportunities in delivering and designing Communication Skills Training across one UK Cancer Network

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Aim: Primary, secondary, independent, National Health Service and Universities worked together to deliver and quality assure network wide communication skills training.
Design and statistics: Developed from short sessions to degree and masters level, there is an agreed curriculum ensuring a similar learning experience wherever the courses are accessed. The programme for clinical, volunteers and administration staff moves from essential skills training to intermediate, topic specific and a 3 day Advanced Communication Skills Training (ACST). Every year nearly 400 participants attend (200 essential, 12 intermediate, 100 topic

specific, 70 ASCT). The training is facilitated from a variety of roles in cancer and palliative care. A 'training the trainer' model is implemented ensuring confidence and competence in delivery. There is a high satisfaction of the learning objectives, content and delivery and evidence that the ASCT changes participants skills and behaviour. Challenges are sustaining the facilitators time, skills, funding, fitting in obligations to employer, targeting health and social care professionals to attend. Benefits include support for participants and facilitators, networking across organisations, collaborative reflection on the programme, choice of academic accreditation, delivering national policy at and by local providers. The way forward - Review of all communication skills sessions to link into future sessions including palliative care competencies, holistic, spiritual and psychological assessments, as well as other end of life groups, widening access and availability of all types of courses to all health and social care professionals, measuring the impact this has for clients and their families.
Conclusions: Working together although challenging in terms of process reaps benefits in terms of participants and facilitators experience and quality assuring a education programme.

PE 1.F86

How to teach about death and dying?

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In spite of the fact that the Czech Republic has undergone a lot of changes and also thinking and attitudes of people have been transforming gradually, approximately 80% of people still die in institutions. The reasons of this situation are multifactorial, one of the most important determinants being an inadequate preparedness of the professional and lay public for dying at home. For death as a common part of life. This paper will inform about the possibilities of preparation of caregivers for their work with dying people. Describe teaching methods aimed at formation and modelling of the students attitudes (branch: General Nurse) towards chronically ill and dying people. For example RWCT, snowbaling, brainstorming:what we know - what we want to know - what we learned, rationale map). Then describe how to use selected teaching methods for:
• definition of the basic concepts (chronically ill people, pain, suffering, dying, death);
• identification of one's own feelings and needs, and self reflection;
• identification of the needs of chronically ill and dying people;
• identification of the attitudes of chronically ill people towards suffering and pain;
• identification of the attitudes of dying people towards death;
• finding the way of support for chronically ill and dying people;
• finding the way of support for the family members of chronically ill and dying people.
The paper is aimed at familiarization with the methodology of the teaching process and evaluation of its benefits.

PE 1.F87

Teaching composure: Enhancing nurses end-of-life skills in a multi-cultural society

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Many hospital nurses feel uncomfortable with death and caring for the dying. Composure, the ability to be there for the dying patient and family, can be taught while addressing personal fears about death.
Aims: A course was designed to provide hospital nurses with a toolkit of skills to improve the quality of End of life (EOL) care in an acute setting. The intervention was measured by 2 questionnaires pre and post course. One measured perceived competence in EOL care and the Death Anxiety Scale (DAS) explored personal fears. An evaluation form was given for feedback.
Methods: 22 female nurses (RN) working in a general hospital aged 25-60 years met for 14 weekly sessions of 2 hours. Their backgrounds included European, Arab, North African, and Ethiopian. Religions were Jewish and Muslim. The myriad cultures reflected those of patients and families.
The toolkit included skills for breaking and dealing with bad news; effective communication; identifying personal fears of death to gain self awareness; religious and cultural acceptance; professional knowledge and standards. Training methods included role playing, group dynamics, workshop exercises and theoretical lectures.
Results: Nurses expressed high satisfaction from the course. They reported improved coping with personal emotions and more confidence when dealing with the dying time. They felt more capable when caring for the dead body and bereaved family. Teamwork was perceived as the main source of strength.
Conclusion: Nurses can benefit from support and training programs to use when caring for the dying in general hospitals. A vital part of nurses achieving Composure in the face of death is addressing personal feelings and fears that can be obstacles to being there for the patients and families at the end of life.
The presentation will include a brief exercise in guided imagery to allow the audience to experience their own fears of death. This insight was at the heart of the course.

PE 1.F88

An innovation in end of life care nurse education

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Aims: Workforce development is a priority of the Department of Health's End of Life Strategy (2008). Hospices, specialists in end of life care, provide inpatient care for 4% of those who die each year and yet over 50% will die in an acute hospital. How can these specialist centres effectively share best practice and contribute to the development of the acute sector workforce? St Christopher's Hospice, Sydenham, was approached by an acute trust hospital Medical Unit to provide training in 'End of Life Care' to the Ward Managers. Each manager was released for one week in small groups of three or four over a period of four weeks. St Christopher's designed a programme which empowered this team to return to practice equipped to make a sustainable difference to patient and carer experience at end of life.
Methods: The programme offered a wide range of learning activities both practical (participating and observing) and theoretical (listening and debating). Each participant spent two of their five days in practice working alongside a specialist ward nurse interspersed with three days working with an educational facilitator. The focus of the facilitation was on providing a supportive learning environment in which participants could reflect on current personal and organisational practice in the light of new information and observations. The new learning was used to inform a collective action plan for self, team and organisation.
Results: The immediate positive impact of the programme on the understanding and attitudes of the participants was evaluated through the examination of data collected from individual reflections and small group work. Feedback from senior nurse managers and the wider multidisciplinary team confirmed increased skills, competence and motivation in the nursing team.
Conclusions: Hospices, as specialist centres, can provide direct, effective and economically viable end of life care training for whole teams of care providers.

PE 1.F89

Tracheostomy care in a hospice setting: A study to evaluate the impact of a tracheostomy teaching intervention and assessment on qualified nurses' level of knowledge and skill

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Background: Small numbers of patients with a tracheostomy are admitted to a hospice (2/yr in our 48 bed unit). They have complex needs and their quality of life can be poor[1]. It is vital that nurses' providing care possess the necessary knowledge and skills. Evidence suggests that nurses are not educated or experienced in this area[2]. Teaching interventions are not always effective in promoting learning[3].
Aim: To evaluate whether a teaching intervention and assessment improved the knowledge and skill levels of nurses' with regards to tracheostomy management.
Methods: Knowledge and skills were evaluated for 25 nurses at baseline and following a teaching intervention. Training was delivered in 3 groups with identical teaching format and facilitators. Knowledge and skills were tested by questionnaire and direct observation. Students were tested immediately after the intervention. Retention of learning was tested in a subset (n=9) ten days post teaching. A group interview was also used to determine the nurses' perceptions of their knowledge and skills.
Results: There was no significant difference in baseline or post-teaching knowledge or skill scores between the 3 groups ($p>0.05$). All scores significantly improved post-teaching [n=25, median (range): Knowledge 16 (7-37) to 30 (15-40), $p<0.001$; Skills 3 (0-8) to 10 (5-14), $p<0.001$]. Furthermore there was no significant change in scores post-teaching to day 10 ($p>0.05$, n=9). Sub-analysis showed greatest improvement in skills rather than knowledge. For knowledge, the greatest area for further improvement was 'emergency equipment' and hence further teaching will address this area in a different way.
Conclusions: This study demonstrated poor educational baseline levels. A focused teaching intervention promoted learning. This study highlighted the need for ongoing education and assessment in this field.
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PE 1.F90

A student self learning module for the palliative care unit: You the learner, the person in your care & the interprofessional care team

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Our aim was to teach learners in health science professions about Holistic Care, Collaborative Practice, and the Humanities (human experience, historical perspectives, ethics and law, professionalism). Learners in undergraduate and postgraduate programs (e.g. medicine, nursing, pharmacy) went to either a module unit or non-module unit for clinical placement. In a pre/post survey design 2 tools were used:
1) Attitudes Toward Healthcare Teams [scores indicate positive attitudes towards working in interprofessional teams on 3 subscales:
i) Physician Shared Role - a shared role for the physician on the team rather than a traditional physician dominant role in decision-making
ii) Team Efficiency
iii) Team Value.
2) Knowledge based questions were developed to measure knowledge gained about Holistic Care, Collaborative Practice, and the Humanities.
Comparing Module vs. Non-Module Learners on the pre and post surveys:
Paired t-tests for the attitude scales showed that module learners changed their attitude more in favour of a shared leadership role for physicians on the team and rated interprofessional team efficiency higher. Chi-Square tests for the knowledge questions showed:
a) no significant difference in their scores [incorrect, partially correct, and completely correct] on pre-evaluations
b) post-evaluation scores improved for 2/5 knowledge questions [Holistic Care and Human Perspectives]: a significantly higher percentage of module learners had completely correct scores.
In conclusion, the self-learning module
a) is an effective tool for teaching holistic care, interprofessional teamwork, and the Humanities in any health science profession
b) can be adapted to undergraduate curricula [teaching basic concepts in classrooms leaves more time in clinical placement to focus on learning activities that promote interprofessional interactions and reflection]
c) framework can be adapted to any topic in any care area.

PE 1.F91

Humour in palliative care - A new concept for education and communication

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We initiated in our palliative care unit an interdisciplinary project to determine the feasibility of humour therapy as a new offering for our patients. Our intent was to train the whole staff to integrate humour techniques into every day clinical practise and communication with the patient. The expression "humour" is used for an overall concept comprising several measures with the goal of general contentedness and improved communication.
Methods: The training of the palliative care team members took place in 10 teaching units. The lessons comprised of oral presentations, role plays, acquiring of humour techniques, creating of humour suitcases for every day work and development of a humour questionnaire. A special humour day with two professional clinic clowns working together with personal and patients is performed monthly on a regular basis. Additionally a new interior design for the palliative care unit will be developed with team and patients.
Results: 90% of our personal actively participated in the training. The overall perception is that it will help to prevent burn-out. The team spirit has increased. Every patient who took part in a humour intervention has been taken by the concept. Humour was helpful in coping with their situation and it increased their mood. The communication with patients was made easier as well. By measuring pain in general with VAS (visual analogue scale) a positive effect was underlined by significantly less intense pain.
Conclusion: For the treatment of our hospitalised patients humour therapy is a noteworthy addition to traditional treatment modalities and a useful communication device. The concept can be easily acquired and adapted to several inpatient and outpatient situations. The benefit for the patients and staff is enormous. Very important is the regular repetition of supervised practice and theoretical background.
We gratefully thank Lions Club Ravensburg and Tognum AG Friedrichshafen for their financial support.

PE 1.F92

Effects of "hospice nursing training program" for dying patients care behaviors of nurses in non-hospice care unit

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Aim: The aim of this study is to describe the care behaviors of non-hospice care unit nurses after "hospice nursing training program".
Methods: This study was a quasi-experimental deigned study. There were fifty nurses attended the " hospice nursing training program". The care behaviors of the nurses were self-reported by structured questionnaire, which was good reliability and validity. All participants completed the hospice nursing training program for two months. Three months after finishing training program, participants self-reported the questionnaire for understanding the knowledge, attitude, and care behaviors during the nursing care. All the participants were informed the purpose and procedure of the study.
Results: All the participants were under fifty years old with average 9.94 years being a nurse. 94% nurses were not working in oncology or hospice unit and 90% having terminal patients care experiences. The findings of this study were supported the training program was useful and satisfied for more than 95% participants. The knowledge was improved. The attitude for some participants was changed but not in statistics significant difference. Furthermore, the confidence of dying care was increased in physical care($p<.00$), psychological care($p<.00$), spiritual care($p<.05$), DNR and hospice communication($p<.00$), as well as family care($p<.00$).
Conclusion: The hospice nursing training program was useful for the nurses in hospice unit as well as the nurses in general units for caring the terminal patients. Also, hospice cooperative care is very important for the terminal patients in non-hospice unit. Thus, hospice nursing training program should be scheduled for all the nurses for the hospice concept, also, deliver the appropriate terminal care for dying patients.

PE 1.F93

Predictors of Spanish hospital nurses' experiences of caring for terminally ill patients

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The quality of care hospitalised terminally ill patients receive needs improvement. Nurses play a central role in the care of these patients. Currently we don't know which personal and professional factors influence nurses' experiences of caring for terminally ill patients; and consequently the care that they provide. This study therefore sought to explore hospital nurses' experiences of caring for these patients and to identify personal and professional factors influencing these. In this mixed method study, a questionnaire was developed on the basis of findings from observational and interview data. A survey was conducted of all nurses working on acute wards with terminally ill patients in eligible hospitals in Navarre, Spain. 165 nurses participated (65% response rate). Factor analysis was carried out to identify the latent structure of nurses' experiences and regression to identify the personal and professional predictors of these.
Results: Factor analysis revealed 5 main factors regarding nurses' experiences with terminally ill patients: 'Learning process', 'Discomfort with death and dying', 'Nature of nursing care', 'Challenges with caring' and 'Motivation to care'. Nurses positively valued the learning experience of caring for terminally ill patients, but perceived care of these patients to be more demanding and challenging than other groups. Competence to care emotionally explained changes in 'Discomfort with death and dying' and 'Challenges with caring'; and post registration education explained changes in 'Nature of nursing care' and 'Motivation to care'. Likewise, support at work explained variance in the factor 'Motivation to care'. Regression models explained between 31% and 12% of factor variance.
Conclusion: Post registration education, support and perceived competence to care emotionally for terminally ill patients need to be tackled in order to improve nurses' experiences with terminally ill patients; and thus the quality of care patients receive.

PE 1.F94

Knowing what to expect may help to cope

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Aim: A Canadian network of researchers, practitioners, students and seniors with an international arm dedicated to improving the care of older adults around the globe is working on research-based communication tools to assist terminally ill persons, their families, friends and caregivers in dealing with various aspects of this important phase of life - including advance directives, education, pain assessment and indicators/symptoms of an approaching death.
Method: The presentation will highlight the work of the network's End-of-Life Issues Theme Team including priority setting, tool development, content milestones and messaging - also featuring care for the caregiver as an often neglected aspect within the continuum of care.
Attention is also drawn to the important aspect of ongoing (program) evaluation/feed-back on tools. The international arm of the network is essential in the review of cultural sensitive approaches throughout the process.
Results: An informational caregiver brochure entitled "What To Expect When Someone Close To You Is Dying", distributed in co-operation with a major Canadian health care service provider, is featured as a specific example. Written in lay terms and translated into major languages spoken by Canada's immigrant population, it tries to assist with the decision-making process and is geared toward ensuring that basic needs for respect, dignity and physical comfort are sustained until the end.
Preliminary data from brochure feed-back is presented as a case in point. Suggestions will be incorporated into future print runs and the online versions of the brochure - available in Adobe PDF-format via the network's website.
Conclusion: Communication tools play an important part in end-of-life care (caregiver) education as knowing what to expect may help to cope.
Funding: Core funding is provided through a grant from the Networks of Centres of Excellence (NCE) and the International Development Research Centre, Canada (IDRC).

PE 1.F95

An integrated four year curriculum in palliative care for medical undergraduates

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Aim: Describe strategies for development, implementation, and evaluation of a longitudinal PC medical school curriculum and the challenges and barriers to overcome.
Methods: This is a retrospective, descriptive study based on data collected during curriculum design and implementation.
Results: Curricular content was designed by an interdisciplinary team including basic and clinical sciences faculty, behavioral and community health sciences faculty, RNs, social workers, spiritual leaders, and students. Pre-clinical students train in patient interviewing and receive lectures and reflective discussion sessions on integral PC topics. Curricula for clinical students include PC modules during the Internal Medicine (IM) clerkship and visits to home hospice patients in Family Medicine (FM). Graduating students participate in a mandatory case-based, interactive module covering key aspects of end-of-life care: hospice, DNR orders, family meetings, pain and symptom management, death pronouncement, and pediatric palliative care. All required clinical rotations will have PC content by 2010. Evaluation strategies include student, patient, and faculty assessments; content questions on student examinations; and Objective Structured Clinical Evaluations (OSCE's). An Office of Palliative Medicine was established at NEOUCOM to coordinate the PC curriculum while a PC Student Interest Group was formed by the student body to focus their interest and efforts in this field.
Conclusion: Efficient use of time and resources has allowed a generalist undergraduate PC curriculum to flourish within a community-based medical school. Sustainability will depend on continued support from the medical school and the community. Ongoing evaluation of the palliative care curriculum will assess physicians' knowledge and skills for meeting patients' end-of-life care needs.
The Robert Wood Johnson and Summa Foundations funded this study.

PE 1.F96

The "Chain of Palliative Care" and the "public knowledge approach" - New concepts for introduction of palliative care to the public

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Aim: To describe concepts that could enhance awareness of Palliative Care in the public, lead to better knowledge about Palliative Care and extensive provision of Palliative Care for the entire population.
Methods: A search was conducted in databases for scientific journals (e.g. Pubmed/Medline, CINAHL), the Internet and reference lists of books and articles. Based on the critical review of existing concepts new concepts and ideas emerged and will be presented. New concepts for the implementation of Palliative Care overall are needed.
Results: There is a great demand for the implementation of Palliative Care in Europe and other industrial countries, especially for old and demented people. Many old and demented people do need Palliative Care but do not have access to it. The knowledge of health professionals and the public about

Palliative Care is low.
Conclusion: Two new concepts are described: The "Chain of Palliative Care" is a model of how Palliative Care may be integrated in the health services and the public. The "public knowledge approach" is a new concept for implementation of Palliative Care in the public and to enhance knowledge about Palliative Care for all health care professionals and the public. A short introduction course in "Last Aid" implemented in the public school education and offered for all interested people could probably be a part of the public knowledge approach to bring Palliative Care into the society. These concepts may prove helpful in spreading basic knowledge in and attitude towards Palliative Care across society.

PE 1.F97

A six-step approach to education in palliative care for ALL

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Aim: To adapt and improve the common three levels of knowledge in Palliative Care for physicians, nurses and other professionals in the field of Palliative Care as described by the European Association for Palliative Care1,2 (EAPC) and the Schweizerische Gesellschaft für Palliative Medizin, Pflege und Begleitung3 (SGPMB) to a approach of knowledge acquisition for everybody. This approach should include all professionals working in Palliative Care and all interested laypersons.
Methods: A search was conducted in databases for scientific journals (e.g. Pubmed/Medline, CINAHL), the Internet and reference lists of books and articles. Relevant guidelines, curricula and recommendations were reviewed.
Results: Recent concepts, curricula and educational efforts in Palliative Care are mostly based on education within one profession, multidisciplinary education is recommended, but is rare to find. Three levels of competence have been described by Palliative Care organisations as the EAPC and the SGPMB.
Conclusion: A six-step approach to education in Palliative Care for ALL is suggested. This approach includes education for the public as basic step. One important feature is the demand for multidisciplinary education for all professionals involved in Palliative Care. Palliative Care organisations and others working with education in this field should discuss and consider this approach.
Literature:
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2. European Association for Palliative Care (2004): A Guide for the development of Palliative Nurse Education in Europe, www.eapcnet.org (10.06.2008)
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PE 1.F98

Teaching medical students about death and dying

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The medical course of the University of Melbourne provides developmentally appropriate teaching, relevant clinical experiences and apposite assessment about death and dying for students which meets their needs in the intern year.
The course is integrated, problem based, with early clinical exposure, increasing complexity of communication skills and professional development (PD) teaching and a Palliative Care rotation.
Information about teaching sessions in the six year course comes from a curriculum database. All Problem Based Learning (PBL) tutorials have learning objectives, such as the challenges and losses that occur when death is imminent; examples are lung cancer and miscarriage. A first year lecture on changing attitudes and practices to death and dying across time and space is followed by lectures on ethical issues in end of life decision making in second year. The PD teaching in the later years includes theoretical and practical approaches to breaking bad news, experiential teaching on confirming the death of a patient sensitively, plus explaining to the family. The last related session is documentation for autopsies, certification of death and disposal of bodies. In the palliative care rotation medical staff conduct teaching ward rounds where students encounter dying patients, and tutorials on end of life care. All assessment is related to the style and content of teaching and includes written questions and Observed Structured Clinical Examinations (OSCEs). A final year OSCE asks the student to demonstrate confirmation of death on a simulated patient and explanation to the distressed daughter.
We questioned the 2005 graduates on their preparedness for internship, as they graduated and at completion of the year. We found that initially 37.9% felt competent to tell a patient they had a terminal illness whereas 54.2% could do this a year later, while 52.1% considered they could provide medical care to dying patients at graduation and 61.3% as interns.

PE 1.F99

Psychosocial skills in palliative care

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Background: An education needs assessment of staff working at the hospice identified psychosocial care as an area of high priority. Staff cited a lack of knowledge and understanding of the key principles, resulting in low confidence in this aspect of care.
Aim: To develop staff who can provide effective psychosocial care to patients at the end of life through the development of a psychosocial training programme.
Method: The project followed the MRC framework for evaluation of complex interventions:
Phase I: In depth interviews with terminally ill patients and health professionals to elicit their views and experiences regarding psychosocial care;
Phase II: Development and delivery of a three day training programme.
Ten health professionals participated in one study day per month for three months. Participants completed: knowledge questionnaires pre and post each study day; an audio-taped patient interaction after day two; an observed audio-taped patient interaction after day three; a reflective diary throughout the programme; a confidence questionnaire pre and post the programme. Qualitative data was subject to thematic analysis.
Results: Analysis of the knowledge questionnaires indicated participants had a more detailed understanding of the concepts relating to psychosocial care. Participants felt the use of reflective diaries, audio-tapes and observation enabled them to critique their own practice. Confidence questionnaires showed an increase in scores for all categories. Participants said their increased confidence enabled them to be more responsive to patient cues and prompts, even when the subject area was difficult.
Conclusion: The MRC framework facilitated the development and testing of the training programme. Phase II highlights modifications required to both the programme content and duration, and also the evaluation methods adopted. Further work is required to evaluate the impact on the patient experience.

PE 1.F100

Understanding to palliative care among Chinese cancer patients

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Aims: Palliative care department in Cancer Hospital, Fudan University is the first palliative care division that was set up by tertiary cancer specialist hospital in China. For little awareness of public understanding to palliative care, the author did a survey from the patients with advanced cancer and made a brief transcript under informed consent. Through the review and sum up, we studied understanding and practical attitudes of the patients to palliative care, and told patients the real meaning of palliative care so that finally more systematic palliative care can be accepted to improve the quality of life.
Methods: Data were collected from the patients in palliative care department and outpatients division, who were mentally clear and agreed to communicate with no language obstacle. Typical represents to palliative care were selected to illustrate the current reality of mind and understanding in Chinese people.
Results: The cognition was divided into two categories, namely one can not accept the reasons, including: literal misunderstanding, advanced cancer treatment misunderstanding, the absence of certain policies, traditional ethics' influence, ignorance of the media, concealing diseases to the family, bias of the oncology doctors to palliative care; other is to accept the reasons, including: active acceptance and passive acceptance.
Conclusion: Although there are a huge crowd with advanced cancer in China, palliative care which was carried out lately is a relatively weak subject with imbalance in development, mainly due to lack of awareness of the people, together with the social, policy, media, family members of patients, ethics, doctors and other reasons. Advanced cancer education and palliative care ideation should be spread to doctors and patients. However, with the gradual development of palliative care, some people have started to accept it. Along with its human services and social recognition, palliative care will be further developed in China.

PE 1.F101

Sustainability of train the trainer education in palliative care

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Question: Does a Train the Trainer Course induce enduring change and increase of palliative care-teaching competence in university lecturers?
Background: An international group of experienced palliative care educators offered two train the trainer courses in palliative care for 100 university lecturers in 2006 and 2008, each course with a length of 8 days, a faculty of 14 and 50 participants.
The training combines content, methods and teaching reflection. Participants switch from learner role into teaching role and vice versa.
Method: Selfassessment Questionaire before, directly afterwards and 6 months after the training interrogating palliative care competencies, attitude versus caring for patients and their relatives and change of competence to educate palliative care with methods taught in the train the trainer course.
Results: 70% of the participants returned the three questionnaire. First results show changes in educational activities: practicability of content and methods, development of new teaching lessons, lecutures and seminars. The data interpretation -still in progress - will be presented.
Conclusion: Programms combining content, methods and teaching reflection can enhance teaching activities and encourage implementing palliative care education for undergraduate students in medical faculties.

PE 1.F102

Lay Teaching - Enabling palliative care clinicians to provide spiritual care education

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Aims: The diagnosis of a life-threatening illness can have a profound effect on an individual and those around them. This can lead to questions such as 'why me' and 'how will I cope?' One of the key aspects of providing effective palliative care is ensuring that spiritual support is provided when and where it is required. Spiritual care is the role of all those who meet these patients and not only faith leaders. As such this project examines how we can support palliative care clinicians to provide effective spiritual care.
Methods: A Spiritual Care Subgroup of Merseyside & Cheshire Cancer Network, Supportive Care Strategy Group has developed a study day on raising spiritual care awareness for those who care for patients with palliative care needs. A handbook has been designed based on this study day to enable other palliative care clinicians to provide this education throughout the cancer network. A pilot of the handbook was undertaken in which physicians and clinical nurse specialists hosted a spiritual care study day based on the handbook. Their hopes and fears were reported before and after the study day. The handbook was modified based on the experience of the pilot study days.
Results: This poster describes the effectiveness of the Handbook alone, in enabling palliative care clinicians to deliver the study day.
Conclusion: All those providing palliative care to patients at the end of life should be able to provide spiritual care appropriate to their role. To allow clinical

staff to do this effectively they require education, experience and confidence in their abilities. Following the initial pilot, the Spiritual Care Handbook is to be rolled out to provide an educational programme throughout the Merseyside and Cheshire Cancer Network for 2009.

PE 1.F103

The emotional care load - Palliative care nursing in community settings

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This research proposes that nurses working in community settings are engaged in more intense relationships over longer periods of time with their clients. In these new nurse-client relationships the nurses need enhanced competencies and a new model of supportive supervision.
This study used an exploratory qualitative design, combining a program-like evaluation and a thematic approach The program -like evaluation was used to assess the outcomes of a non-managerial model of supervision and the themes evolved from the issues raised by the nurses.The participants were eight registered and practising nurses. The sample included one male and seven female nurses working across a variety of community settings.
The nurses agreed to take part in a supervision program, consisting of six one-hour sessions conducted on a monthly basis for a six-month period.
The interviews took place within the supervision sessions where the supervisor/researcher responded to the client issues that the nurses brought in for discussion.
Findings from the analysis are presented in two parts. The first part reported findings from the program-like evaluation. The evaluations revealed that nurses´ perceptions of their overall competence and confidence increased. Their competence levels were measured within four domains, self-regulated learning, self-awareness and development, skill competence and strategies for psychosocial intervention. The second part of the analysis comprised developing themes from the issues raised by the nurses. Four themes were identified:
1. Conflicting demands
2. Containment Strategies
3. The Emotional load and its impact on the nurse
4. The nurses experience of the supervision sessions.
These results demonstrate the complexity of issues that need ongoing professional development and point to a model of supervision that can provide the space fro both education and support.

PE 1.F104

High tech volunteering in palliative care

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Aim: To provide a platform using widely available internet technology for palliative care professionals to teach, interact, and exchange ideas with fellow colleagues in places around the world where the knowledge gap is wider than the technology gap.
Methods: Palliative Care Network (PCN) is a volunteer initiated project. It's website (www.palliativecarenetwork.com) was created in June 2007. The project evolved from a successful long distance mentoring project between a physician in Los Angeles, USA and Mumbai, India.
PCN´s directory gives palliative care professionals worldwide access to colleagues for providing educational support. Palliative care specialists submit their contact information to this website. Once the information is posted in the directory, the participants are then encouraged to reach out to others in the directory with whom they may want to communicate or to whom they can be of service. Guests visiting this website who would like educational support must search the directory for a suitable match and then establish contact.
Results: To date, seven successful partnerships amongst various palliative care professionals form different parts of the world have been reported. Impact of the project is reflected by the feedback from Dalitso Mzinganjira, " I am a nurse from Malawi. I would like to thank Dr. Zipporah Ali and Stephanie Reynolds, both of whom I contacted via Palliative Care Network, for providing me education and information to pursue my education in Palliative Care. Without the existence of PCN, I wouldn´t have probably been able to pursue with my palliative care career. I wish to encourage others to take advantage of this network in advancing Palliative Care services in their areas."
Conclusion: PCN provides an opportunity for palliative care professionals to volunteer and help other colleagues around the world at minimal cost, as per their convenience.
This project is funded by volunteers who run and maintain the site.

PE 1.F105

Palliative care for psycho geriatric patients from a physiotherapeutic view

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Aim: Physiotherapy (PT) aims to "optimise the patient's level of physical function and takes into consideration the interplay between the physical, psychological, social and vocational domains of function. The physiotherapist understands the patients underlying pathological condition, but this is not the focus of treatment. The focus of physiotherapy intervention is, instead, the physical and functional sequelae of the disease and/or its treatment." (Fulton and Else, 1997).
The focus is on facilitation of movement. Often this facilitation is understood as activation, exercise and training. This focus might confront with the ideas of Palliative Care, so it is important to explicit the alternatives in PT, with regard to Palliative Care. The best place to this is in PT education through research projects (Case Studies) performed by students.
Design: In Case Studies is shown how the focus of PT (in a interdisciplinary perspective) fits harmoniously in Palliative Care. The central hypothesis of the studies is: Facilitation of Movement in Treatment of Psycho Geriatric Patients; the Alternative Way.
Results:
1. Use of a vacuum cleaner in order to facilitate walking, bending, stretching.
2. Stimulation of movement leading to diminishing the dose of psycho pharmacy.
3. Paradox between fixation (prevention of falling) and freedom (autonomy) of movement.
Conclusion: Current thoughts in healthcare are focussed on Comfort instead of Psychosocial factors*. Comfort rules and regulation are about safety (prevention of falling by fixation), medical (pharmacy) and physical care (food and weight rules). The Stimulation (movement, touch, music) can be included until the last phase of care. PT is indispensable for 'stimulation' of touch and movement. In education programmes this PT approach is taught by research projects.
* Lindenberg: overall feeling of wellbeing (quality of live): Affection, Behavioural confirmation, Status, Comfort and Stimulation.

PE 1.F106

Learning from challenges and opportunities in the recruitment of patients with advanced cancer within a hospice/palliative day care setting

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Background: We are currently actively recruiting approximately 420 patients from hospice/palliative day care units in the North West region of England as part of a large multi-centre quantitative study to determine the prevalence, aetiology, and natural history of depression and demoralization in patients with advanced cancer. There is extensive collective experience of all aspects of recruitment for palliative research within the research team. Nonetheless, we have experienced considerable practical challenges and opportunities in recruiting for this study, and as a result have identified important lessons for future research in this area.
Aim: To identify challenges and opportunities relating to the recruitment of patients with advanced cancer to a research study, and gaining access/collecting data within a hospice/palliative day care setting; and highlight lessons for future research.
Method: A review of learning from reflections elicited at regular research team meetings about challenges and solutions to facilitate access and recruitment of patients.
Results: Experiences varied, but a number of common challenges and opportunities were identified:
(i) Patient reaction to sensitive issues
(ii) 'Conspiracy of silence/closed awareness'
(iii) Issues concerning recruitment, including 'gatekeeping', the 'obligation' to take part, and researcher presence in the hospice environment
(iv) The role of emotion and reflexivity of the researcher
(v) Peer support and formal access to therapeutic supervision for the researcher.
Conclusion: Identified solutions and strategies for overcoming the challenges and enhancing the opportunities in undertaking research with patients who have advanced cancer within a hospice/palliative day care setting will be shared.

PE 1.F107

The age of sophisticated educational browsing: Google Scholar vs Pubmed

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Background: With between 13,000 and 25,000 scholarly journals estimated to be available online, the internet provides a wealth of information to both clinicians and medical students. Finding useful, relevant publications efficiently requires a robust tool.
Objectives:
Part 1: To identify to what extent Pubmed and Google Scholar are used by medical students.
Part 2: To compare the results produced by the two search engines in a variety of searches.
Methods:
Part 1: An online survey was available to 1184 students and was completed anonymously.
Part 2: 5 searches with a palliative and supportive care theme were performed and 737 results were analysed.
Results:
Part 1: 387 students responded to the survey. Both Pubmed and Google Scholar were used to a similar extent by medical students.
Part 2: Pubmed returned less citations but found less 'false hits' than Google Scholar. Google Scholar was able to find free full-text versions of useful articles that Pubmed did not and also provided links to potentially useful 'grey-literature'.
Conclusion: Over half of the medical students who responded to the survey used one or both of Pubmed and Google Scholar to search for medical literature. This will undoubtedly contribute to their learning as qualified doctors. Pubmed is able to transform a simple query box entry into a sophisticated search, and its methods are transparent. Google Scholar is able to find peer-reviewed and useful 'grey' literature that Pubmed does not and so is a useful adjunct to a Pubmed search. We recommend that the different methods of searching and advantages and disadvantages of each should be taught at medical school.
Funding provided by the local university.

PE 1.F108

Teach the teachers: Implementation of palliative care in long term care for the elderly

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Aim: A small minority, in Europe 2 - 5%, of severe ill and dying elderly patients are met with competence in palliative care. The vast majority of dying elderly and their relatives will not receive proper: pain relief, preparing communication, skills in ethical decision making, psychosocial and spiritual care in the patient's final days and hours. Our aim was to develop and test a model for implementation of palliative care towards frail elderly persons in their home or in long-term-care facilities.
Method: A curriculum and a teaching program were developed with main content: 2-4 members of caring staff from home care or nursing homes in Norway attended 4 seminars for 3 days over 1 year. We start 2 programs each year. Staff receive basic and detailed lectures in palliative care for the elderly. Extended presentation-, curricula- and publication-materials were handed out. The participants had to commit themselves to train and make their own presentations

under supervision, and to plan and establish their own local teaching program on these topics after having fulfilled teaching program. The local places of the participants receive a kick-off local seminar with lectures from a member of our team in the following months.
Results: 2 groups with 47 participants fulfilled the educational program. Hardly any of them had experience or skills in teaching or presentations. All developed local projects for their own municipality or nursing home. Until now we visited 9 of their home areas, where local kick-off seminars were arranged, totally with more than 2100 participants. The program is over-booked for the next years. We plan to publish the concept and results internationally in the following year.
Conclusion: The multiplicator benefit of a teach-the-teachers program: Palliative Care for Elderly Persons, is overwhelming, and the need for these programs are imminent.

PE 1.F109

Targeted competencies for palliative medicine speciality?

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Aims: Deficiencies in care for the dying have been well documented in the literature. Medical students and interns describe themselves as unprepared to care for dying patients. To address this issue, a training of 2 years will be proposed to French medical students, but to adequately address medical students needs' in end-of-life care we need to identify: What competencies are required? What tools should we use to improve our medical training?
Methods: Two focus groups were formed, with respectively sixth grade medical students (n = 10) and national palliative medicine teachers (n = 20). Qualitative content analysis of these groups reflections' was performed.
Results: Medical students identified 5 competencies to develop: interpersonal competency (e.g. communication skills), management of social issues, specific symptoms management, teamwork, and introspection. Our results confirm what is found in the literature, with the exception of emotional and spiritual issues which were not mentioned as important domains. They indicate that clinical rotations are the best way to learn these competencies, and underline also the educational benefits of role-plays. In return, teachers reported 4 distinct competencies labelled as technico-scientific, interpersonal, ethical, and ability to collaborate with other health professionals. They mentioned clinical exposure as the best way to learn end of life care, mobilisation and feedback from tutors, and written reflections in a portfolio structure as important educational tools.
Conclusion: Major competencies in palliative medicine identified in this study have been already described as relevant competencies for all medicine practitioners. However, daily practice in palliative care involves specific "types of situations" which should be addressed in a specialized training. Description of these "types of situations" is a prerequisite for effective planning and subsequent assessment of palliative medicine training.

PE 1.F110

A survey of the provision of palliative care continuing professional education in the republic of Ireland in 2008

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Aim: A national survey of palliative care continuing professional education (CPE) activities at level 8 and below of the National Framework of Qualifications was undertaken in the Republic of Ireland in order to set up an internet database.
Methods: The full range of organisations and service providers offering palliative care CPE at generalist and specialist levels was unknown. A sample (n=130) of potential providers across the Republic of Ireland was identified through consultation. Each provider was emailed a questionnaire seeking demographic details, subject content, learning outcomes, methods of assessment, target audience, accrediting bodies, academic level, duration, fees, awards, and dates of each palliative care CPE activity they provided or planned to provide in 2008. Data were analysed using SPSS Statistics 17.0.
Results: A 57.69% response rate to the email was obtained (n=75) and 41.33% (n = 31) reported the survey was not applicable to their organisation or service. Completed questionnaires were returned by 44 providers. Six questionnaires were discarded as incomplete or not applicable. Data were collected from 38 providers, based in 13 of the 26 counties of the Republic of Ireland. In total, data were generated on 162 formal and informal palliative care CPE activities. Of these, specialist palliative care (56.8%) which includes hospices was the most frequently cited provider of CPE. Main topics included bereavement (12.1%), communicating around dying (11%), symptom management (10.3%) and psycho-social issues (9.7%).
Conclusion: There is a broad range of palliative care CPE which would appear to slightly favour the psycho-social dimension over symptom management. More information is required on detailed curricula, course content and learning outcomes. Based on this study, an internet database to provide an all-Ireland informational portal on palliative care education is planned for 2009. This study was funded by the Irish Hospice Foundation.

PE 1.F111

Expanding non-malignant palliative care services in an Irish hospice: A multidisciplinary educational needs analysis

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Aim: To ascertain palliative care staffs' perceived educational and training needs in relation to expanding palliative care services to people with non-malignant conditions in a Dublin Hospice, in order to inform future educational programme developments, thereby promoting successful expansion of current palliative care services.
Methods: An educational needs analysis was conducted. An 11 item questionnaire was circulated to all (n=145) palliative care clinical staff working in a leading Dublin hospice. Following SPSS 17.0 and thematic analysis, a multi-disciplinary focus group was conducted to gain richer insight.
Results: A questionnaire response rate of 40% represented all disciplines. 41% of respondents reported current education needs were not being met. 71% considered that caring for patients with non-malignant conditions requires additional education and training. Disease specific educational needs (e.g. dementia, renal, cardiac, respiratory disease, neurological) focused on treatments, trajectories, prognostication, symptom management, pharmacology, ethical issues, patient and family support, and integrating care with other specialities. 62.5% expressed concerns about people with non-malignant conditions engaging in palliative care services, such as lack of resources, expertise, knowledge, funding and preparation, challenges with prognostication, and dilution of current service. 52% identified barriers to meeting these education needs such as lack of time, limited funding, inequitable study support, and inaccessibility of disease specific experts to deliver educational programmes.
Conclusion: Experienced palliative care practitioners identification of specific educational needs is frequently hindered by inherent apprehension regarding expanding services. Listening to concerns is imperative alongside tailoring collaborative teaching with the disease specific specialists.
This study was funded by Our Lady's Hospice Ltd.

PE 1.F112

Developing a novel education programme on end of life care for professional carers

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Background: Care is frequently procured from independent agencies, to enable patients to die in their own homes. This care is delivered by untrained carers and the quality is dependent on the individual practitioner. Evidence suggests that care agency staff have varying degrees of knowledge and experience in end of life care.
Aim:
• To equip professional carers with the knowledge and skills required to deliver equitable, quality care for patients at the end of life within their own homes.
• An introduction to palliative care, an understanding of end of life issues and promote confidence in managing a crisis.
• To identify the roles and responsibilities of their role.
• The opportunity to network with other colleagues and their local specialist palliative care team.
Method: Interviews were undertaken with care agency managers to ascertain the perceived educational needs of carers. The results were used to develop a one day foundation course. Three courses were held in six months, all were evaluated at the end and a telephone interview was held with a random sample of attendees six months after the course.
Results: 58 carers from eight local agencies attended three courses, which included:
• Introduction / philosophy of palliative care
• How to manage a crisis - recognising symptoms using case studies
• End of Life - diagnosis of dying/managing symptoms / promoting comfort
• Using equipment
• Basic communication skills - communicating with semi-comatose patients / families
• Spirituality
• Caring for yourself.
The courses were all well evaluated. At follow up, interviewees valued an understanding of the dying process and improved confidence in communicating with the patient, family and other professionals about end of life issues. All expressed a wish for further education.
Conclusion: These results confirm that this novel education programme can affect practice, thus improving end of life care for patients at home, who require professional carer support.

PE 1.F113

Addressing suffering through effective collaborative teamwork: Innovations in on-line learning

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Aim: Interprofessional education (IPE) is a response to the need for more effective, collaborative, person-centred teamwork. Implementation challenges for IPE include scheduling common learning times across curricula and designing programs to meet needs of the different learners. This project explored the use of an on-line learning module, combining independent and group learning activities to address common and profession-specific learning objectives.
Methods: The dynamic, facilitated module uses a patient narrative, developed by students, to portray a patient experiencing a complex combination of physical, psychosocial and spiritual issues ("suffering"). Learners choose a unique navigation strategy. No one learner can navigate the whole story, so they must share their understandings to develop a collaborative care plan. With ethics approval, volunteers were recruited to pilot the module. Evaluation data included pre-post responses on a validated 'Attitudes Towards Health Care Teams' questionnaire; pre-post case study reports; a learner satisfaction questionnaire; a three-month post-module survey.
Results: 21 students, representing nursing, medicine, spiritual care and physiotherapy completed the module. Nineteen were women; 56% had experience with on-line learning; 53% had previous interprofessional experiences. High pre-module attitudes towards health care teams increased slightly. All were highly satisfied with the learning experience. Pre-post case studies showed learners doubled their identification of spiritual and physical issues and identified the need for teamwork five-fold.
Conclusion: Students increased both their appreciation of the need for health care teams and the components of suffering.

PE 1.F114

Project "developing competence in pain treatment of medical teams and clergymen by transfer of Polish professional experience into Ukraine"

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Introduction: There are 13 medical centres providing stationary palliative care in Ukraine, however, home care is not provided and there are no pain treatment outpatient clinics. Among painkillers representing the second group of analgetics tramadol is available, as far as the third group is concerned it is morphine in ampoules. However, strong opioids are not available for home patients. A fear of drug addiction is not only the most serious social and mental, but most of all legal barrier.
Aim: Assessment of options of pain treatment, identification of barriers.
Methods:
1. Establishing cooperation with palliative care organization in Ukraine;
2. Acquiring a source of financing - a grant of the Polish-American Freedom Foundation for:
• Organization of internships in pain treatment in palliative medicine centre in Lodz
• Organization of 2-day training courses in 2 Ukrainian cities - Lvov and Ivano-Frankivsk
• Joint work with the Ukrainian partner on assessing the condition and identifying problems related to tumour pain treatment.
Results and conclusions:
1. Medical staff may recognize problems related to pain treatment and palliative care, they are interested in developing their knowledge and skills in this filed
2. The way to improve the condition of tumour pain treatment in Ukraine is to:
• Introduce amendments to legal regulations concerning painkillers application: increase an access to opioids, introduce oral morphine, provide access to morphine at pharmacies and patients' homes;
• Organize training courses for staff working at hospices and staff employed in other specialization fields: internal medicine specialists, general practitioners, oncologists, social welfare employees;
• Develop a network of outpatient clinics specializing in tumour pain treatment;
• Change social stereotypes.

PE 1.F115

Effect of palliative care teaching and community hospice visit on medical students´ knowledge and attitudes toward care of terminally ill cancer patients

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Introduction: A majority of medical students feel uncomfortable with terminally ill cancer patients. Increasing attention in medical education is being paid to end-of-life care. Since 1997, under the Department of Community and Family Medicine, Far Eastern University-Nicanor Reyes Medical Foundation has provided lectures on hospice and palliative care to first year medical students. Starting academic year 2008, a mandatory 16 hour lecture for fourth-year medical students on pain management and principles of palliative care and a one-day visit at a community hospice was implemented during their community and family medicine rotation.
Aim of investigation: To determine the effectiveness of intensive lectures and a community-based hospice visit in changing palliative medicine attitudes, knowledge and skills among fourth-year medical students.
Methods: Pre- and post-test questionnaires incorporating self-assessment of knowledge, attitudes and skills toward care of terminally-ill patients are administered to fourth-year medical students before and after completion of their community and family clerkship rotation.
Results: In general, prior to their rotation, students report a deficit in their knowledge of pain management and ability to perform palliative medicine tasks. Students reported improvements in the items measuring knowledge of cancer pain management after completion of the rotation. However, they continue to lack confidence in performing palliative medicine tasks and to report discomfiture in interacting with terminally-ill patients after completion of the rotation.
Conclusions: Though lectures improve medical students' knowledge on pain management and care for terminally-ill cancer patients, a longer hospice based rotation may be an effective model for facilitating learning about how to approach the patient with a terminal illness.

PE 1.F116

Basis for the development of educational curricula regarding rehabilitation in palliative care

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Cancer impacts on patients' quality of life. However, issues such as rehabilitation(R) in Palliative Care(PC) are poorly explored. Education in PC focuses on impairment, with emphasis on symptom control and psychosocial and spiritual support. R is hardly advocated as a basic teaching objective. International PLATO Project (Palliative Care Learning Together) proposes to enhance R in practice through strengthening this topic in the educational curricula (Newell-Jones, K.) Within this framework, this research intended to build up the basis for integrating R in health professionals(HP)' education.
Objectives:
1) Agree on a common definition of disability(D) and R in PC, according to current literature and experts' opinion.
2) Explore concepts of D and R in PC from the perspective of advanced cancer patients(ACP), relatives and HP. A non systematic revision related to R in PC setting was carried out.
Data: Databases Medline/Cochrane. Seminal PC textbooks and articles, reference lists of seminal publications, local legislation. Research-team meetings were accomplished to define the concepts of D and R for adult ACP in PC. In-depth interviews to 5 ACP and carers were undertaken. 2 Focus Group Discussions (FGD) were conducted among HP.
Data analysis: Interviews and FGD were recorded, transcribed verbatim and double checked. Data were appraised by 2 independent researchers, building consensus after qualitative analysis. If no consensus reached, a third researcher intervened. We agreed Whiteneck and Holicky's "Expanded Model of Disablement" provided us with a theoretical foundation for D in ACP. We achieved a definition of R, reaching face and consensus validity. Emerging topics were identified from ACP and Caregivers' Interviews and FGD' analysis. This study brought in clarifying concepts and triggered questions related to R in ACP. Further research is needed to elaborate evidence-based recommendations underpinning education addressing this issue in PC.

PE 1.F117

Development of teachings in palliative care for medical students in Germany

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Aim: In Germany, the development of undergraduate Palliative Care teaching is a slow process, as is the discussion about inclusion of Palliative Care teaching as a mandatory subject in the curriculum of medical education. The aim of the present study was to collect present data on Palliative Care teaching at German medical schools to create a basis for further discussion.
Methods: The Working Group on Palliative Care of the German Medical Students' Association (GEMSA) sent a standardized questionnaire to all deans of studies of the 36 German faculties for medicine. All information gathered was compared with information collected two years ago by the working group in the same way. The questionnaire dealt with the following items:
1. Type of teaching course,
2. Organisation,
3. Other courses with similar contents,
4. Presence of a palliative care unit in the university hospital/teaching hospital,
5. Possibility of spending part of the last year of medical education in a palliative care unit,
6. Notes.
Results: In all German medical faculties Palliative Care has found its way into the teaching curriculum. Compared with 2006, we found a clear increase in the number of courses offered. Sadly, Palliative Care courses are only mandatory in 6 out of 36 universities, and thus reach only a small percentage of medical students. Facultative courses exist in all the universities but very highly in form and contents and in many courses only partial aspects of Palliative Care are represented.
Conclusion: Our register of the current state of undergraduate medical teaching in Palliative Care in Germany can be (and is) used for further establishment of teaching structures by professors and by students in medical faculties. The Working Group on Palliative Care of the GEMSA recommends the inclusion of Palliative Care as a mandatory subject in the German curriculum of medical education.

PE 1.F118

Are before-after studies appropriate to determine the effectiveness of physicians' training in palliative care?

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Aims and objectives: End-of-life care is still a developing part of medicine, and there is a special need for the education of residents and other physicians including those with special certifications who have no experience in palliative care.
Therefore, different training models have been developed during the last years to improve physicians' knowledge and skills regarding end-of-life care, and before-after-studies have been undertaken to evaluate the effectiveness of these educational sessions. Our aim was to evaluate the appropriateness of before-after studies and their special methods to evaluate the effectiveness of physicians' palliative care training.
Methods: We did a medline search to identifiy before-after-studies within this field (search words: palliative care, hospice, training, education, physician, nursing home) using the function "related articles" where appropriate. Data of training settings, outcome measures and reported results were extracted and compared.
Results: Three studies with a before-after design were identified: two measured the outcome of a physician's training by employing self-assessment methods, and only one looked for effects on the patient's comfort, although these data were drawn from routine records. If knowledge tests were done, a highly significant short term improvement of a physician's knowledge could be shown, but no long term results were provided. The study which looked at the patients' level evaluated a time interval of 6 months after the training session and found highly significant improvements in pain and symptom control as well as in dyspnea and in several other features of pre- and post- intervention data which were compared.
Conclusions: There is a strong need for studies which measure the effectiveness of a physician's training in palliative care by prospectively looking for changes in patients´ comfort. To evaluate the sustainability of training effects, long term measurements need to be done in addition.

PE 1.F119

Undergraduate education program - Do we need to work it out?

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Introduction: Despite the development of Palliative Care in European countries we still lack consensus on unified program of undergraduate training for medical students and nurses. What is more symptomatic palliative care is still not present in the curricula of medical studies on many European universities. The growing number of patients requiring palliative care in the aging European society indicate the urgent need for recognition of the problem.
The goal of the paper is to present the program of undergraduate education at Poznan University of Medical Science.
The programme was introduced in 1990/1991 thanks to the initiative of profesor Jacek ?uczak and has been developed within years to 53 hrs of seminars, workshops and practice at the bedside that students attend on the 5th and 6th year of the medical studies.
The syllabus includes:
• introduction of palliative and hospice care, the philosophy and goals
• history of palliative care in the world and in Poland

• organisation of palliative care
• ethical dilemmas at the end of life with special attention to palliative sedation
• psychosocial issues and the role of psychosocial support
• communication with the patient and family
• nursing patients with the advanced diseases
• end-of-life care
• epidemiology, pathophysiology, assessment, pharmacotherapy of pain
• pathophysiology and treatment of respiratory symptoms (dyspnoea, cough, haemoptysis)
• pathophysiology and treatment of gastrointestinal symptoms (nausea and vomiting, gastrointestinal obstruction, constipation)
• anorexia/cachexia syndrome- pathomechanism and treatment
• nutrition in palliative care
• psychiatric issues (delirium, depresssion)
• emergencies in palliative care
• lymphoedema, fungoid tumors, chronic wounds and pressure sores.

The comprehensive system of education in holistic palliative care for patients with cancer and other incurable diseases is awaited. Poznan experience may serve as an example to be taken for further consideration.

PE 1.F120

Multiprofissional learning and teaching in palliative care

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Aim: Interdisciplinary team work is the main issue to provide holistic palliative care by coordinating the contribution of different professional disciplines. An important issue for this purpose is that all health professionals involved in a team must share common knowledge besides each specific training. Our academic palliative care unit developed in the last five years two pedagogical strategies with a set of similar subjects organized with the same structure: a conventional face-to-face master course (12 months) and a blended learning post-graduate intensive course (3 months). Our teaching strategies in palliative care integrate always in the courses different health professions with natural predominance of doctors and nurses both from hospital and community health centres.
Our aim is to evaluate the levels of cognitive knowledge at the beginning and at the end of these two kinds of pos-graduated courses in a sample including the total number of doctors and nurses participants in the courses.
Methodology: 210 participants from master courses (N= 81, 21.0% male, 39.5% doctors, 60.5% nurses, 63.0% hospital settings, 30.9% community health centre) and blended learning post-graduated courses (N= 129, 24.0% male, 43.4% doctors, 56.6% nurses, 31.8% hospital settings, 65.9% community health centre), were assessed by expectancy questionnaire and pre and post- multiple choice test.
Results: At the beginning of the courses there were significant statistical differences between the total scores of doctors and nurses ($t=4.20$, $p<0.0001$) and in half of the areas cognitively evaluated (14). At the end of the courses these significant statistical differences decreased ($t=2.18$, $p<0.03$) and there no significant statistical differences in almost all areas (27).
Conclusions: With these two kind of courses we reached for all health professionals (doctors and nurses) a common level of knowledge in a very significant number of areas.

PE 1.F121

Social work in hospice and palliative care: The emerging landscape

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Social Workers in the US provide the majority of psychosocial services in Hospice and Palliative Care. Their contributions in education, research, administration, and policy development are increasingly recognized and have become integral to the development of this emerging field yet no single organization was established to advance their perspectives. This presentation examines the state of palliative and end-of-life care social work within the US and within the international community. Creating a proactive vision was the working goal of two Social Work Summits on End-of-Life and Palliative Care. A priority item identified at the 1st Summit in 2002 and the overarching consideration of the 2nd Summit in 2005 was to create a social work coalition of experts, institutions, organizations involved with end-of-life and palliative care to promote advocacy, education, research and networking.
The Social Work Hospice and Palliative Care Network (SWHPN) emerged from the Social Work Leadership Development Awards Program,funded by the Project on Death in America. In June 2007, SWHPN was officially established as a nonprofit organization with 501c3 status, a board of directors, and elected officers. SWHPN now has a large subscriber base for public website updates and growing membership base in its private online community. It's initial goals were to build consensus within the profession, create intra-professional and interprofessional partnerships, develop a social work specific knowledge and skill base within end-of-life and palliative care, disseminate information to the social work community at large (national and international), and across professions, collaboration on program initiatives and resource sharing, and ultimately further development of capacity and advancement of the field. The results of an ongoing needs assessment survey of Social Workers practicing in this area supported by the Academy of Hospice and Palliative Medicine will be reported.

PE 1.F122

'Birds of pray!' - A religious needs resource

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Background: In response to the NICE Supportive and Palliative Care Guidance UK 2004 Merseyside and Cheshire Cancer Network convened a Spiritual Care Subgroup to review the recommendations of Chapter 7, Spiritual Care. This group conducted a baseline spiritual care audit across Merseyside and Cheshire Cancer Network, looking at the assessment of spiritual and religious needs and the provision of spiritual and religious care. The results of this have been reported elsewhere. As part of the same audit health professionals were asked about their confidence in providing spiritual and religious care and their educational needs. The results showed that the majority of health professionals recognised their own lack of confidence and need for education and resources to help them meet the spiritual and religious needs of their patients.
Response: In response to the results of this audit a number of initiatives were undertaken. This poster presents one of these which is a website of information about religious beliefs, key issues, and practical information related to end of life care. This website resource is freely available to all health professionals via the Merseyside and Cheshire Cancer Network. The poster describes the contents of the website resource, how it has been used and the results of initial evaluations.

PE 1.F123

Examination of quality of life for older people in receipt of palliative care and older people in continuing care facilities, with specific reference to dignity and respect

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Background: As the proportion of Irish people aged 65 years and over continues to grow over the coming years, it is likely that demands for health care services, including residential care settings will increase.
Aim and objectives:
1. To explore older people's perceptions of factors which impact on their quality of life with particular emphasis given to exploring non-illness related factors, particularly dignity and respect.
2. To explore older people's needs in relation to factors impacting on their quality of life, particularly dignity and respect.
3. To explore with older people any interventions which they can identify which would contribute to their quality of life given their particular circumstances.
Methods: The study has two phases; Study 1 uses a qualitative grounded theory approach by implementing one-to-one in-depth interviews to examine participants' perceptions and experiences of the factors impacting on their quality of life, particularly dignity and respect. Study 2 involves a survey measuring physical, psychological, social, and spiritual well-being. This paper will focus on Study 1.
Analysis and results: Data analysis was undertaken using the constant comparative method of grounded theory. This method involves the researcher identifying similar and deviant elements and grouping them together around a theme for comparison. Data from the interview transcripts was managed using the computer package NVivo, which allowed a large data set to be managed and ensured that a clear decision trail was authenticated from the data.
Results define the meaning of dignity for an older Irish population, and portray incidents which have effected the participants' sense of dignity, impacting on their quality of life.
Conclusions: Interventions are highlighted which seek to maintain dignity, an essential component of quality of life for older people in palliative and extended care facilities.

PE 1.F124

Improving the experience of dying patients: Evidence from 10,000 deaths in Wales

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The implementation of an Integrated Care Pathway (ICP) for the last days of life across Wales has resulted in the centralised collection of over 10,000 patient variance sheets resulting from the delivery of end of life care through the ICP in various care settings. The ICP is based on evidence and best accepted practice in the absence of evidence. ICP variance sheets record instances where care has differed, or varied from the expected goals and also provides evidence of delivering quality end of life care. Analysis of the reported variances indicates that pain, agitation and excess respiratory secretions or rattle are consistently difficult symptoms when managing care of the dying patient. Tracking these symptoms over time we showed a sustained improvement from 50% decreasing to 28% of patients with persistent symptoms of pain, agitation and excess respiratory secretions.
Although the ICP variance analysis shows improvement 67% of patients achieved the goals of being 'pain-free', 'not agitated' and 'no rattling secretions' these symptoms remained problematic for 33% of patients (n=10126). This finding is despite the use of recommended medications and working to an accepted high quality model of care. The indications for research are for fully powered trials to identify the most effective interventions for the optimum management, of these symptoms and initiate the establishment of an evidence base to underpin guidelines in palliative care. There are known limitations for the design of trials in palliative care and an innovative approach is called for, to identify a suitable methodology for use in trials involving dying patients.

PE 1.F125

Importance of nutrition therapy for patients in the terminal phase of cancer - Activities of a palliative care nutrition support team

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Background: Care of terminal cancer patients must include maintenance as well as improvement of immunocompetence and wound healing ability through appropriate nutritional management. A palliative care nutrition support team (PC-NST) was established in our institution in 2003 to provide optimal nutritional management for such patients. The results achieved by this team are reported here.
Results:
1. Severe nutritional disorder was observed in 87.7% of the patients on admission, and improvement was noted in 54.4%. Many patients had normal serum levels of albumin but a low RTP level on admission; however, patients who showed nutritional improvement also had an improved RTP level.
2. The duration of "oral-intake possible" conditions significantly increased from 26.8 days before introducing PC-NST to 53.9 days at 3-year post-introduction.
3. The survival time was significantly prolonged from 35.7 days before introducing PC-NST to 57.9 days at 3-

year post-introduction.
4. Glutamine-fiber-oligosaccharide (GFO) therapy for cancer patients on oral morphine/oxycodone was initiated by PC-NST. The duration of "oral-intake not possible" conditions was significantly reduced in GFO-treated patients (5.6±7.1 days) compared to non-GFO-treated patients (19.0±21.1 days). The use of laxatives was also markedly reduced associated with GFO therapy.
Conclusions: The introduction of PC-NST has led to prolonged duration of "oral-intake possible" conditions and survival time. Before introducing PC-NST, an important number of patients died of iatrogenic causes such as opportunistic infection, while after its introduction, few cancer patients have died of a non-cancer cause, suggesting a substantial improvement of the QOL of cancer patients. The results also suggested that GFO therapy in opioid-treated patients may increase their immunocompetence, prolong duration of "oral-intake possible" conditions, and prevent or improve opioid-induced constipation.

PE 1.F126

Enhancing end-of-life care in the community

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Aim: To develop an evidence-base for a medication practice in community nursing and make recommendations for best practice. People moving towards end-of-life often desire to die at home. Hence, community nursing organisations in South Australia provide home-based palliative care (PC) services to facilitate this desire. Nurses prepare single doses of injectable medications in polypropylene syringes which are left in domestic refrigerators, for later subcutaneous administration by informal carers to provide immediate symptom relief. However, there was little evidence to support this practice.
Method: Data sets included: qualitative enquiry with 11 PC nurses and 14 informal carers and an investigation of the sterility, stability and potency of specified medications used in PC. Literature was reviewed to identify stability and potency data of these medications in polypropylene syringes. When such data were not available, stability testing was commissioned. The sterility of syringe contents was determined by analysis of the contents of 'test' syringes, stored in a domestic refrigerator for 28 days. The clean technique of a sample of community nurses was also tested.
Results: Interviews revealed that the practice was highly valued by nurses and carers. It allowed patients to remain at home, surrounded by family and friends, with resultant improvement in quality of life. The stability and potency data showed that the majority of medications were suitable to be drawn up and stored for longer than the current period of 24 hours. Testing of the nurses' clean technique and the contents of 'test' syringes did not reveal any bacterial contamination.
Conclusion: Best practice recommendations addressed on-going sterility testing, medication storage and disposal, and development of educational materials for nurses and carers. Project outcomes included a work instruction for registered nurses, an advice sheet and a break-through medication chart for informal caregivers.

PE 1.F127

Improving end of life care in care homes in the United Kingdom: An evaluation of the Care Homes End of Life Supportive Services programme (CHESS)

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Background: Care Homes End of Life Supportive Services (CHESS) builds on a palliative care programme originally undertaken by Leeds Primary Care Trust as part of the Gold Standards Framework in Care Homes (GSFCH) initiative. This initiative, merged with a number of other developments identified via the Marie Curie Cancer Care Delivering Choice Programme Leeds project, was supported and developed via key stakeholders and funded by Marie Curie Cancer Care. CHESS is a service improvement programme which aims to support care homes in the delivery of quality palliative care, and improve the resident and family experience of care delivery during the last 6-12 months of life. CHESS was piloted in 33 care homes in Leeds (UK) during 2007 / 08.
Aims: This independent evaluation aimed to ascertain whether or not CHESS was effective in improving end of life care in care homes.
Methods: A mixed methods approach was used, including a survey of all participating care home staff specifically trained to undertake and organise CHESS, in-depth semi-structured interviews with a wide range of stakeholders, and documentary analysis of relevant material.
Conclusion: CHESS appears to have had a positive impact on end of life care for residents in participating care homes. Improved communication between homes and community health care agencies was reported, as was greater care home staff confidence and awareness over end of life issues. Carers and care home staff responded positively to the formalisation of end of life care protocols. Areas requiring development included: the need to differentiate more clearly between the needs of care homes and nursing homes; the need to target particular homes; and difficulties in sustaining staff momentum and interest in the programme. Increasing numbers of people are receiving end of life care in care homes. Chess, as a local service improvement programme with key stakeholder engagement has the potential to improve levels of care for this group.

PE 1.F128

Quality of EOL policy in a large tertiary hospital: Differences among specialties

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Aim: Dying in the Intensive Care Unit (ICU) versus on non-critical wards and frequency of do-not-resuscitate (DNR) decisions are quality indicators of a hospital end-of-life (EOL) policy. The aim of this study was to compare quality indicators of EOL policy between different wards.
Methods: The study was performed in the Ghent University Hospital, a tertiary hospital of 1062 beds with all medical and surgical disciplines present, including organ and bone marrow transplantation and major oncological surgery. First, data concerning EOL decisions were collected in all adult patients who deceased during a 12-week period in 2007 and a 16-week period in 2008 and who were admitted at least 2 days on a non-ICU ward in their final hospitalisation (in whom it was possible to address EOL issues). Secondly, the frequency of DNR decisions for all patients > 16 years old admitted on non-critical wards were studied using a one day cross-sectional observation.
Results: Surgical patients were more often referred to the ICU at the EOL in comparison to medical patients (12/17 (71%) versus 73/209 (35%), p<0.001) despite similar Charlson comorbidity score. Dying patients on non-critical surgical wards had a DNR option at the time of death in only 5/9 (56%) versus 14/168 (92%) patients on the medical wards (p=0.007). Similarly, a DNR decision was installed in only 1% (4/485) in surgical patients compared to 23 % (187/815) in medical patients (p<0.001) in the cross-sectional study. A huge variability in frequency and timing of DNR decisions and subsequent participation of patient, family and nurses in these decisions and in ICU admission and length of stay in the ICU at the EOL was also observed between medical wards.
Conclusion: Transition from acute care to a more palliative approach is less anticipated on surgical wards compared to medical wards. There is also a huge variability in EOL practice between medical wards.

PE 1.F129

'Whistlestop tours?' A pilot of rapid ambulance transfers at end of life

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Background: The first U.K. National End of Life Strategy (2008) highlights the need for coordinated services to provide rapid, easy access to those services required to enable people to be cared for & to die in the place of their choice, which for the majority is their own home. NHS North West's 'Healthier Horizon's' (summary recommendations of 8 clinical pathway groups response to the U.K. Darzi NHS Review) outlines an aim to achieve a 10% reduction in hospital deaths by 2012 & rapid discharge pathways for people in acute care who wish to die at home, including a 2 hr target for ambulance transfer.
The North West Ambulance Service (NWAS) currently provides transport for end of life patients moving from one care setting to another. However transport at end of life is provided within existing commissioning agreements for Patient Transport & Emergency Services, with no specific standards in relation to end of life care. Although within West Lancs, Southport & Formby (WL,S&F), over the last 5 years, the number of hospital deaths has reduced from 56%-48% & the number of home deaths has increased from 15%-21%, a number of issues have been experienced regarding transport booking, delays & incorrect provision, which may contribute to preventing further improvements in enabling people to move to the place of their choice at this time in their lives. Pilot project: NWAS & WL,S&F Palliative Care Services have developed a pilot rapid transfer process & monitoring system to manage patients at the end of their life, who want to die at home or in another care setting, within an agreed timeframe of 2 hours, from the booking of ambulance transport to the transfer being undertaken.
Results: This poster describes the project & outlines the results of the attempt to meet this target along with the challenges & obstacles along the way. The outcome of this pilot is the substrate for developing a definitive service for end of life care ambulance transport in the North West of England.

PE 1.F130

Advance care planning in advanced cancer - Can it be achieved? A patient preference trial of a care planning discussion

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Background: Patients with recurrent cancer may have concerns about future needs and care. Enabling a discussion of advance care planning (ACP), as suggested by recent DH policy, might facilitate an increase in openness between patients, families and professionals.
Aim: To determine the acceptability and feasibility of an intervention consisting of up to 3 discussion sessions with a trained mediator to facilitate planning for end-of-life care.
Method: A patient preference randomised controlled trial. Cancer patients with active disease were approached in NHS oncology out patient clinics. After informed consent, they expressed their preference for or against receiving the ACP intervention. 20 places guaranteeing ACP and 20 usual care were available in a preference arm. All other participants were randomised to the intervention or usual care. Measures at baseline and follow up (at 8 weeks) included HADS, visual analogue scales to assess communication with family, friends and clinicians, and possible completion of a written advance directive. Qualitative data were collected on reasons for choices and preferences. ACP discussions were audio-taped and analysed for thematic content. They were structured to cover previous experiences of care, current problems and concerns, fears for the future, the role of close persons, and options for a written advance directive.
Results: Resistance was encountered from clinicians who lacked confidence to introduce the study to eligible patients. 78 participants entered the study and recruitment ended in August 2008. The follow up rate is 80%. We shall describe our study population, the feasibility of randomisation, recruitment rates and attrition, and trends for change in outcome measures. We shall present emergent themes from qualitative analysis of ACP discussions. Analysis will be complete by January 2009.
Conclusion: This study provides evidence to inform the acceptability of introducing ACP discussions in end of life care.

PE 1.F131

Prognostication by the multidisciplinary team - Are we accurate?

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Background: Patients in the last few weeks of life progressively deteriorate requiring increasing physical, psychological, spiritual and social support. It is therefore important to identify this patient cohort.
Aims: To determine the accuracy of the multi-professional Hospital Specialist Palliative Care Team (HSPCT) in identifying patients with a prognosis of 6 weeks or less. To provide evidence supporting recommendations for advanced care planning and resource allocation for patients in the last few weeks of life.
Method: A retrospective study of all referrals to a HSPCT in North-West England from April to July 2007. Since May 2006 the HSPCT multidisciplinary team meetings (MDTM) have identified and recorded patients' expected 6 week survival based on the statement: "I would not be surprised if this patient died within the next 6 weeks".
Survival outcomes for these referrals were obtained from Hospital and Hospice records. The expected 6 week outcomes were compared with survival outcomes and analysed using Microsoft Excel.
Results: 318 referrals for 250 patients were received during the study period. 225/318 were discussed at MDTM. 129/225 (57.3%) died within 6 weeks of MDTM discussion. 45 (20.0%) patients were identified as being in the last 6 weeks of life at MDTM. The MDT approach using the statement "I would not be surprised..." against actual outcomes gave the following; sensitivity 29.5%, specificity 92.7%, positive predictive value 84.4% and negative predictive value 49.4% for identifying a prognosis of 6 weeks or less, with an accuracy of 56.4%.
Conclusion: Accurate prognostication is required to improve end of life care. HSPCT referral often occurs when the patient has far advanced disease, and prognosis is poor. The multidisciplinary approach using the statement "I would not be surprised ..." identifies some of these patients but many more die within this time. This difficulty in identifying poor prognosis and late palliative care involvement affects patient care.

PE 1.F132

End-of-life care for seniors: A Canadian research team

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Aim: The End-of-Life Care for Seniors New Emerging Team (ELCS-NET) was funded in 2003 by the Canadian Institutes of Health Research to develop and conduct an interprofessional research program to improve the quality of care for seniors at the end of their lives. The team of researchers represents medicine, nursing, social work, psychology and epidemiology and focuses on seven main themes:
- end-of-life care for rural older adults; settings of care;
- sense of burden;
- role of volunteers;
- delirium outcomes;
- symptom recognition and management; and
- interprofessional education.

The objectives of this team program of research include:
1) address priorities which link the fields of gerontology and palliative care,
2) mentor junior researchers and graduate students;
3) collaborate with national and international palliative care researchers;
4) promote knowledge translation for policy, education and practice in end-of-life care.
Methods: The team members utilized qualitative, quantitative, and mixed methods. The research program is structured to investigate the four components of the quality of end-of-life care model by Stewart et al: (1999), including Personal and Social Environment; Structure of Care; Process of Care; and, Outcomes of Care.
Results: Highlights from selected studies will be presented including:
- Continuity of care for community-based palliative care services
- A rural palliative care model
- Clinical guidelines for delirium
- Patient's sense of burden
- Hospice and homelessness.

Conclusion: The team has been successful in meeting the program objectives and will share plans for sustainability.
Main source of funding: Canadian Institutes of Health Research.

PE 1.F133

Diagnosing dying: Exploring the process by which palliative care staff recognise the last days of life

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Aim: To improve understanding of how hospice staff recognise & identify the dying phase, defined as the last few days of life.
Background: Recognition of the dying phase is a vital process in end of life care. The Liverpool Care Pathway for the dying patient exists to facilitate good quality end of life care, but its use relies on healthcare staff identifying when patients have entered the dying phase. This can be challenging at times, especially for those less experienced in end of life care such as in acute hospital settings. Without this recognition, care of dying patients may be sub-optimal.
Method: An ethnographic qualitative study designed to examine how hospice staff, experienced in end of life care, recognise the dying phase, performed in 3 stages. 1- Retrospective casenote analysis examining staff documentation of the last days of life. 2- A prospective period of observation of hospice staff during clinical meetings where decisions regarding diagnosis of dying are often formulated and discussed. 3- Semi-structured interviews with hospice staff.
Results: 25 casenotes were analysed by content analysis, totalling 175 days of entries in the 7 days leading up to death. Over a 6 week period, over 13 hours of clinical meetings were attended & observed. Staff interviewing is progressing at present. Staff participation levels were high, from a range of professions including medical, nursing, allied health, social work & spiritual support. Results to date indicate the process of identifying the dying phase is complex & multi-factorial. Factors considered include physical findings such as changes in breathing, skin tone, consious level, oral intake and mobility. Non-physical factors such as patient statements & psychological state were also influential, along with staff feelings of intuition or "gut instinct".
Conclusion: Diagnosing dying can be challenging & is a complex process. Ongoing interviews will provide further insight & expansion to additional units is planned.

PE 1.F134

Palliative care in acute leukaemia in a Swedish region during 2004-2005

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Aims: A retrospective study of the palliative measures taken in patients who died of acute leukaemia in our region.
Materials and methods: Names of patients from 18 years of age that died in our region during 2004-2005 with acute leukaemia were provided from our register and The Swedish Death Register (SDR). Information from the journals was registered retrospectively.
Results: Acute leukaemia was registered as a cause of death in 49 patients, M/F ratio 25/24.
Subdiagnoses were: Acute myelogenous leukaemia (AML) 29 patients, secondary AML 14 patients, acute lymphatic leukaemia (ALL) 5 patients, Chloroma 1 patient. Places of death: 37 patients at hospital, 5 at hospice, 2 at a nursing home and 5 at home. 33 patients received an induction therapy, and 18 patients obtained a remission.16 patients received palliative care only.
A decision on strictly palliative care was finally taken in 42 patients. In 7 cases there was no time to decide about palliative care.
The relatives were informed at the time of diagnosis in 42 cases, in 4 cases when decision was made for palliative treatment. 3 patients had no relatives.
Median time from diagnosis to death was 11 months.
The patients received 0-161 units RBC per patient (median 39), and 0-97(median 19) units of platelets per patient. The out-patient visits were an average of three times per month. The inpatient's days ranged from 1-267 days, (median 65).
In 16 of 49 journals, contacts with a social worker are registered. 5 patients had contact with a supportive care nurse, 1 patient with a priest and 1 with a deacon.
A mobile team nurse gave transfusions at home. She visited 9 out of 34 patients from the university hospital, range 1-48 visits (median 15). 23 patients had contact with a primary care nurse.
Conclusions: The patient and their relatives were well informed. Few patients died outside hospital. Too few were offered emotional support. The mobile team and the primary care teams could be utilized better.

PE 1.F135

Supporting end of life care in care homes: A survey

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Aim: The delivery of end of life care in care homes depends not only on the skills of staff, but also access to support outside. This study examined what factors influence the provision of end of life care to older people in English care homes registered to provide nursing.
Methods: We designed a questionnaire for completion by care home managers or senior clinical staff to examine the support they accessed in providing end of life care. The questionnaire was piloted for face validity and mailed to 180 care homes, spanning a rural and urban area of northern England. The survey area surrounded two in depth case studies, to be reported separately.
Results: The response rate was 46%. Of those homes which responded: 57% provided information about care home size (19-180 beds) and residents' deaths in the last year (76% residents died in the care home; 77% non cancer); 80% were implementing an 'end of life care pathway' most commonly the Liverpool Care Pathway (66%); 72% had "a lot" of support from GP's, specialist palliative care nurses and district nurses and "some" support from family members and social workers; 56% said that support received varied with resident's illness and stage. Qualitative comments provide insight into barriers to care: variable and inconsistent GP support; discriminatory attitudes; lack of information about services/ resources/ training; poor 'out of hours' cover. Respondents had clear views about their priorities for enhancing end of life care: meeting residents and families needs; improving the care home environment; staff training and education; using end of life pathways; networking.
Conclusion: As acknowledged by the Department of Health´s End of Life Care Strategy for England, care homes for older people are an important site for end of life care. This study sheds light on what support care homes need and highlights areas for improvement.
The NHS End of Life Care Programme has funded this study.

PE 1.F136

'Preferred Priorities for Care': Experiences of patients, families and practitioners in using an advance care planning tool

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Aim: 'Preferred Priorities for Care' (PPC; formerly named 'Preferred Place of Care') is a patient-held advance care planning document used in the UK with patients facing serious illness and end of life. Although supported by the national End of Life Care Programme, PPC has had little research. The aim of this study was to evaluate the experiences of patients, family members and health care professionals in using this document in the setting of palliative and end of life care.
Methods: This study took place in the North West of England where the PPC originated. We conducted semi-structured interviews with a purposive sample of community-based and hospice-based nurses, patients and family members who had utilised the PPC

document. Nurses were eligible for inclusion in the study if they had initiated a PPC document with someone diagnosed with cancer; patients and family members were eligible if they (or their family member) were diagnosed with cancer. Interviews were audio-recorded, transcribed and qualitatively analysed using standard thematic analysis. Analysis was conducted by a multidisciplinary team of researchers to evaluate the process and experience of PPC utilisation.
Results: Clinicians, patients and family members who have utilised the PPC document offer a broad range of perspectives on the quality of this experience. Participants provide detailed feedback on the process of using the document, advantages they perceive from having used PPC, and barriers to its use. Results reflect personal, professional, organisational and cultural issues. The data offer insights relating specifically to PPC and more broadly to advance care planning.
Conclusion: People who have used the PPC document are willing and able to express their perspectives on their experience of using this advance care planning tool. Their perspectives offer important insights that can inform the design and implementation of advance care planning in palliative and end of life care.

PE 1.F137

A model of collaborative working in end of life care for patients with a non cancer diagnosis

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Aim: There is evidence that patients with a non cancer diagnosis have similar palliative care needs to those experienced by patients with cancer; that many do not receive adequate palliative care and that access to specialist palliative care is inequitable. A project was designed to enhance collaborative working between community matrons and palliative care nurse specialists with the aim of ensuring that patients receive optimum end of life care, at the right time and by the most appropriate professional, irrespective of diagnosis.
Methods: The project provided a range of educational and networking opportunities for community matrons and nurse specialists through study days; focus groups; informal meetings and joint visiting. This process of research and consultation informed the development of pathways to identify decision-making in end of life care and to clarify the role of specialist palliative care. The first is a palliative care pathway tracking the patient's journey when death is anticipated. The second identifies the rationale and referral criteria for specialist palliative care. It is supported by a diagram illustrating the levels of specialist palliative care intervention. An urgent care pathway reflects decision-making when there is an unanticipated change in a patient's condition.
Results: Evaluation shows that the community matrons and nurse specialists have a more supportive, working relationship, with a clearer understanding and appreciation of each other's roles. The pathways are perceived as a helpful guide in end of life care management, although there are some limitations. They have been adopted by two Primary Care Trusts as a framework for mapping end of life services and are used within the hospice education programme.
Conclusion: Further evaluation of the impact on patient care and the usability of the pathways is planned. The results (available spring 2009) will be used to re-design the pathways and inform future developments.

PE 1.F138

Requests to forgo potentially life-prolonging treatment and to hasten death in terminally ill cancer patients: A prospective study

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Background: The most far-reaching choices patients are confronted with during a terminal illness are related to end-of-life decisions. To support terminally ill patients and to contribute to their quality of life it is essential to fully understand the reasons for their choices concerning end-of-life decisions.
Aim and objectives: This study investigates the background and evolution of requests to forgo treatment and hasten death in terminally ill cancer patients.
Methods: Physicians participating in a nationwide study on end-of-life decision-making completed each month a questionnaire about a terminally ill cancer patient they were treated, whose life expectancy was longer than 1 week but no longer than 3 months, until the patient's death (n=85). The questionnaire provided information on the patient's symptoms, concerns, and requests involving end-of-life decisions.
Results: Most patients suffered from cancer of the gastro-intestinal tract or the respiratory system, 66% died within two months after the initial interview. The prevalence of requests involving end-of-life decisions increased during the last 3 months of a patient's life. The evolution of a request was especially related to an increase in the number of severe symptoms and concerns. Requests to forgo treatment were related to general weakness, while loss of dignity was a major reason for requests to hasten death.
Especially the physical suffering blended by psychosocial problems lead to request for euthanasia. The intensity of suffering influenced significantly patients wish to die.
Recommendations: The results emphasise the importance of gaining insight in patients' suffering in order to provide them meaningful assistance and to support them to cope with their hopeless suffering.

PE 1.F139

"Unbearable suffering": The experience of patients with an actual request for euthanasia

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Unbearable suffering is a necessary but unclear condition in the context of a request for euthanasia or assisted suicide (EAS). Our integrative review made clear that it is a profoundly personal perception of an actual or perceived impending threat to the integrity or continued existence of the whole person, with a significant duration and a central place in the mental life of the subject. It also made clear that further patient centered qualitative research on suffering in the context of a request for EAS is necessary.
To gain insight on an empirical basis into the concept of unbearable suffering in situations where a request for EAS is made from the point of view of patients.
Thirty face to face in-depth interviews, using an interview guide, with patients with an actual request for euthanasia. Analysis took place using the grounded theory of Glazer and Strauss and by aid of the computer program Atlas.
Analysis of the interviews provided an extended list of factors and motivations that contributed to the development of an actual request for euthanasia. Themes evolving during our analysis were among others: life history, life events, personality characteristics, advance directives, physical symptoms, psychological symptoms, complications of medical treatment, quality of life, purpose in life, thoughts about ways of dying, fears, loss, hopelessness, autonomy, take farewell and planning death.
We found that most patients participating in this research made advance directives long before the diagnosed disease. Their longtime existing thoughts about euthanasia gradually turned into an actual request as result of experienced loss of all what made life worth living and inevitable progress of limitations and symptoms caused by their disease or situation. The absence of any prospect of recovery all gave them a feeling of senselessness to endure or fight the situation. Their actual request for EAS appeared to be the outcome of a careful decision-making process.

PE 1.F140

29 cases of long survival cancer patients treated with exclusive best supportive care: Brainstorming around palliative chemotherapy

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Aim: In several patients, affected by cancer in advanced or metastatic stage, chemotherapy (CHT) could offer low results in terms of prolonging survival. Aim of the analysis is to evaluate if it's possible to purpose an alternative approach to this selected population of patients.
Methods: We analysed rectrospectivally survival's data of patients that has been admitted to a palliative setting without CHT because of age or concurrent pathologies, or that were early shifted from CHT to best supportive care (BSC) because of intolerance to the CHT treatment. We considered only advanced or metastatic disease, and we excluded patients with only bone metastatic disease.
Results: We analised data about 29 patients; primary tumor sites were: 11 lung, 7 colon, 3 kidney, 3 bladder, 2 brain, 3 other sites. Main metastatic sites were: 12 lung, 7 liver, 6 abdomen (other than liver), 4 brain. At the data collection time, 21 patients died and 8 were alive. 26 of 28 patients were older than 65 years. The mean survival for all patients was 427 days (14,2 months); the mean survival for alive patients was 391 days (13 months).
Conclusions: Data obtained by the analisys of this population suggests that an approach with BSC like first treatment option could be suitable to answer to clinical needs of selected patients with advanced or metastatic neoplasia. Palliative CHT has to be used for symptomatic patients or delaied to refractory symptoms appearence, if performance status is enough and there are chances to get symptoms regression, avoiding useless therapies and earlier impact on quality of life.

PE 1.F141

Palliative oncology care in 2009: Which?

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Premise: Fairchild (2008) demonstrated that high dose palliative radiation therapy (PR) improves survival rates in advanced lung cancer compared to low dose, much like palliative surgery (PS) for metastatic colorectal cancer (Cummins 2004) AIM To analyze therapies and their outcome in cancer patients with survival rates of less than 1 year in a western European country.
Method: The study of cancer patients treated in the Vidas inpatient hospice, one of 3 different palliative care settings of the Vidas Palliative Care Organization (Milan, Italy). Period of reference: 2006-2008. Deaths occurred within 1 year of diagnosis. Clinical and psycho-social conditions of the patients were analyzed, as well as the proposed palliative care and its outcome.
Results: Patient sample: 252, 29.6% of the total inpatients (850). Males: 57.5%. Average age: 74.6 years (range 16 to 97), 46.8% were between 65 to 79 years of age. Prevalent diagnosis: lung cancer 30.5%; pancreatic cancer 9.5%; gastric cancer 7.5%; colon cancer 6.3%. At the beginning of hospice care 49.6% had dyspnea, 20.65% were cachectic, and 8.3% had vomiting, 3.8% psychomotor agitation, while 99.3% had a performance status of 3 to 4. Survival rates after diagnosis: average 140 days (range 20 to 365); median 119 days; 62.9% of patients survived more than 90 days (Group A), 32.2% survived less than 90 days (Group B). Group A received: palliative chemotherapy 24.5%; PR 12.2%; PS 14.2%; hormonal/immunotherapy 0.6%. 44.5% of this group did not have comorbility. 25.8% had no family.
Conclusion: Data from Group A showed that palliative anticancer therapy was proposed for a limited number of patients with survival rates of less than 1 year. The study of Groups A/B has been completed. The analysis identified those aspects which need to be further examined: when/how to integrate palliative care and palliative anticancer treatment as to prognosis; what outcomes should be proposed so as to better respond to the needs of patients/families.

PE 1.F142

Facing death as part of end of life care

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The phenomenon "being with" that relates to what the patient is experiencing when close to death is an important aspect underlying end of life care. The aim of this observational study was to generate adequate description of how nurses and nursing care assistants do "being with" in day-to-day nursing practice within a hospice setting as part of end of life care. Observational data was collected over an 8-month period in an inpatient hospice in Scotland in 2002.
In this reseach I reflect and interpret the way that nurses and nursing care assistants constructed their care for dying patients. I came to understand that the nurses and the nursing care assistants´ perception of "being with" was in relation to providing 'comfort' rather than facilitating the opportunity of facing death. The consequence of this was that patients were 'comforted' but they were not encouraged to face death even though this was a certainty.
In discussing my data in light of Heidegger's theory and how human beings can face death, I will provide an understanding of how the nurses and nursing care

assistants in this hospice managed to care for dying patients. They constructed "being with" in terms of providing comfort in order to manage their own feelings around death and dying. This research offers some important insights into the tension between the hospice ideology of a 'good death' and the reality of day-to-day practice. This research has implications for education and staff support in relation to provision for end of life care.

PE 1.F144

Seizing the window of opportunity

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Introduction: Recent UK Government initiatives have promoted patients´ choice around their Preferred Place of Care at the end of their lives. This follows research and discussion at both local and national level. One initiative undertaken by Isabel Hospice is the promotion of a pilot project which included the appointment of a discharge co ordinator. The author will demonstrate some of the findings and experiences from this project in the poster.
Discussion: There was complete agreement in the hospice that good communication is at the heart of our work. Discussions around care needs must take place between patients, families and staff from the Multiprofessional team. These discussions need to be initiated so that we do not miss "The Window of Opportunity" for patients particularly when they are patients in our in patient unit.
Carers and relatives cannot make real choices unless they are given information. Research from bereavement care suggests that we need to encourage relatives in their capacity to cope. We have found that involving patients, relatives and our staff in realistic discussions helps to encourage feelings of competency.

PE 1.F145

Factors associated with well-being at the end of life

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Aim: This study aims to identify whether symptoms and patient, disease and care characteristics are associated with well-being at the end of life. Factors relating to symptoms are studied as well. This knowledge is lacking at population levels, and may aid the development of care policy, which may contribute to prevention of suffering at the end of life.
Methods: In this mortality follow-back study, data on diagnosis, place of death, contact with the general practitioner (GP), care aim, symptoms and well-being are collected through the sentinel network of GPs in The Netherlands. This network is representative for all practising GPs in The Netherlands, and covers .8% of the Dutch population. Data were collected by asking the sentinel GPs to fill in a questionnaire for all non-sudden deaths in their practises. Symptoms and well-being three days before death were measured using the Edmonton Symptom Assessment Scale (10-point numeric rating scales).
Results: Patients suffered from an average of 3.3 symptoms with a score ≥4. The factor with the strongest unique negative relationship with well-being is fatigue (p<.0001), followed by pain (p=.01) and depression (p=.05). Strong or consistent factors contributing to symptom levels were less frequent GP-patient contact and diagnoses CVA, haemorrhage, sepsis, and infection.
Conclusion: Physical and psychological symptoms are clearly the most important correlates of well-being. However, focusing solely on physical problems at the end of life is not justified. Sudden conditions may play a role in causing suffering. The data underline the importance of the GP in the care for the dying. The results also provide information for testing predictive models for well-being and symptoms.

PE 1.F146

A qualitative study of the experiences of nurses caring for patients in the hospice setting

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Aim: The aim of this study was to explore the experiences of palliative care nurses caring for patients in the hospice setting. The main objectives of the study were to
• Examine the experiences of the palliative care nurses who provide care to patients in the hospice setting.
• Explore the challenges palliative care nurse face when caring for terminally ill patients.
• Determine what mechanisms palliative care nurses use to overcome the challenges of caring for terminally ill patients.
• Establish what supports palliative care nurses use/do they need to face the challenges of caring for terminally ill patients.
Methodology: This study guided by the grounded theory philosophy focuses on the experience of eight nurses working in a regional hospice unit in Ireland. Ethical approval was granted from the local ethics committee and permission to access participants was granted from the Director of Nursing. Data was gathered using in-depth interviews and analysed using the constant comparative method of analysis.
Findings: Analysis led to the development of the following main categories, making connections, dealing with death and dying and minding myself. The first category of making connections is associated with the nature of the nurse-patient relationship in palliative care. The second category of dealing with death and dying addresses challenges nurses face when caring for terminally ill patients. The final category is minding myself. This highlights what support mechanisms these nurses' use and feel are needed from an organisational level to overcome the challenges of caring for terminally ill patients.
Conclusion: A detailed discussion is carried out and literature is used to support or refute these findings. These study findings are important in illustrating these nurses' experiences, when very little research has been conducted previously on this cohort group.

PE 1.F147

Implementation of the Liverpool Care Pathway documentation in two palliative care units in Iceland - Has it made a difference?

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The Liverpool Care Pathway is a well established and well known document which is used for the last days of life. It identifies key areas of care of dying patients and contains three sections: initial assessment and care; ongoing care; and care after death. The LCP provides guidance for the multidisciplinary team on care of the dying patient and care of families after death. The LCP is used widely in many countries in Europe and was seen as an important tool to improve and coordinate the care for dying patients and their families in Iceland. The implementation on two palliative care units in Iceland was done by following 10 Step continuous quality improvement programme for care of the dying using the LCP framework, from the Marie Curie Palliative Care Institute.
Base review was done to provide a baseline of current practice, staff teaching sessions before implementation and audit after the first 20 pathways used.
The poster will show some of the results of the base review and the 20 first pathways used and a discussion on the impact the Liverpool Care Pathway has made, such as changes in thinking among staff members, advanced planning and coordination of care.

PE 1.F148

Working together - Pulmonary rehabilitation and palliative care

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Background: Current guidance suggests that pulmonary rehabilitation should attempt to optimise the individual's physical, emotional and social performance.
Pulmonary rehabilitation programmes should include multi component, multidisciplinary interventions for patients with advanced Chronic Pulmonary airways disease. In line with national guidance and the End of life strategy, Specialist Palliative Care are routinely involved in delivering teaching sessions in local programme to address end of life issues.
Method: An eight week programme is planned delivered primarily by occupational and physiotherapists. Specialist palliative care delivers a single one hour session. Participants complete questionnaire pre and post delivery.
Results:
Presession questionnaire -
5% of patient's associated palliative care with end of life, 5% with pain management, 90% had no understanding.
5% of patients believed only patients with cancer need palliative care. 5% stated that palliative care was for the terminally ill, 90% had no idea.
20% of respondents felt palliative care had something to offer them.
20% demonstrated some awareness of advanced planning.
Post session questionnaire -
80% of respondents felt less daunted about palliative care. All felt that palliative care was not appropriate for them just now.
100% of patients stated that the Palliative Care Pulmonary Rehabilitation session was useful for gaining information.
20% of patients stated that they would like further information regarding Palliative Care.
Conclusion: Patients attending Pulmonary rehabilitation have little understanding or knowledge about the progressive nature of their illness. End of life discussions are not perceived to be happening by this group of patients. Further research is needed to examine this further.

PE 1.F149

The views, experiences and needs of older people in relation to end of life care

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Background: Many older people worry about life-limiting illness towards the end of life and have few opportunities to find out about care options or how these might fit with their values and circumstances. There is a need to improve information for older people, families/friends, and health/social care professionals (HSCPs) regarding both the planning and provision of end of life care.
Aim: To explore end of life care (EOLC) concerns and experiences of older people and inform the development of appropriate information materials about advance care planning and end of life care support.
Methods: We recruited 79 people from six older people's community and self help groups in England to a series of focus group and follow up meetings (38 females, 41 males; ages 35-84 years). The participants discussed EOLC experiences and reviewed an EOLC information booklet from a previous study. Focus group data was analysed using a framework approach, with findings and further involvement in the study discussed at the meetings.
Results: Many participants described negative experiences of EOLC for family, friends or partners. Dissatisfaction was expressed about the support and information provided and delays in accessing services. Advance Care Planning (ACP) was perceived as a good idea but difficult to enact: many said relatives are reluctant to talk about death, dying and care planning. Several reported HSCPs as poor at communicating about EOLC issues. EOLC experiences are reported as having a significant impact on bereavement both in the short and long term. Available information materials can be helpful but often are not accessible or up to date. Various suggestions about style, content and format of

information were offered.
Conclusion: Many older people have concerns about end of life care, often based on difficult experiences of caring and bereavement. Older peoples' needs for support and information warrant further attention.
Main source of funding Burdett Trust for Nursing.

PE 1.F150

To go on living or to die? Perceptions of chronic physically ill Swiss people

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In Switzerland every year 200-250 chronic physically ill people contact an organisation for assisted suicide like EXIT or DIGNITAS and decide to end their lives with their assistance. Some Swiss hospitals and nursing homes allow the chronic physically ill who dwell in these institutions and who wish to end their lives with the help of such organisations to do so within the institutions. To date there is little research about the perceptions of this population and about the decision-making processes they go through before deciding to terminate their lives. This lack of systematic information/knowledge represents a serious problem for Palliative Care the aim of which is to support the chronically ill in a way that allows them to stay alive. On this background the aim of this study is to examine what brings chronic physically ill people to think about giving up their life voluntarily rather than going on with it. The findings will be incorporated in future discussions and planning of Palliative Care.
To explore this so far scarcely researched substantive field the Grounded Theory Approach is used. The individual steps of the research process (theoretical sampling and data collection) and of the process of theory generation (data analysis, developing codes and conceptual statements and a beginning theory) follow the relevant methodological instructions. The research sample consists of adult chronic physically ill Swiss people and their significant others.
The preliminary results available at present are based on 40 interviews. They describe the circumstances under which chronic physically ill Swiss people start to think about assisted suicide and lead them to terminate their life or to go on living. This study is funded by the Käthe Zingg-Schwichtenberg-Fonds of the Swiss Academy of Medical Sciences (SAMW).

PE 1.F151

All deaths, all causes, all settings - A prospective all deaths audit

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Aims: In the UK there is an increasing drive for patients to be able to die in their own homes. The use of tools such as the 'Preferred Priorities of Care' document, the 'Gold Standards Framework' for Primary Care, the 'Liverpool Care Pathway for the Dying Patient' and more recently the publication of 'The End of Life Care Strategy' are giving support to the changes to which need to happen within our health service to allow more patients to die at home. We aimed to examine where patients in our locality were dying and identify obstacles to achieving the patients preferred place of care.
Methods: Following a successful retrospective Cancer Deaths Audit, in the area, carried out in 2006, a prospective audit of all expected deaths, from all causes, in all healthcare settings, in the Southport & Formby and West Lancashire area over a three month period was performed. This included deaths in the hospital, hospice, nursing homes, community and elsewhere. Data was collected on the actual place of death, preferred place of care of the patient and carer, use of the Liverpool Care Pathway and possible reasons for avoidable hospital deaths.
Results: Preliminary results of the analysis are shown in this poster.
Conclusion: Analysis of how and where patients die in our area will enable us to understand where end of life care is occurring. This information will allow us to target changes in services to where they are needed most.

PE 1.F152

EAPC framework for institutional guidelines for the use of Sedation in Palliative Care: A work in progress

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Sedation in the context of palliative medicine is the monitored use of medications intended to induce varying degrees of unconsciousness to induce a state of decreased or absent awareness (unconsciousness) in order to relieve the burden of otherwise intractable suffering. Lack of due concern for the risks involved and problematic practices can lead to bad and sometimes unethical practices which may compromise the credibility and reputation of the responsible clinicians and institutions as well as the discipline of palliative medicine in general. The EAPC believes that the potential distress caused by these situations are adequately grave, to justify the need for institutional guidelines to protect the interests of patients, their families and involved clinicians. The EAPC is preparing a framework for such isititutional guidelines: the current draft includes 10 specific recommendations.
1. Preemptive discussion of potential role of sedation in end of life care and contingency planning
2. Providision of clear indications in which sedation may or should be considered.
3. The guideline should provide description of the necessary evaluation and consultation procedures.
4. Outline consent requirements
5. The necessity to discuss the decision making process with the patient's family.
6. Selection of the sedation method
7. Direction for dose titration, patient monitoring and care.
8. Decisions regarding hydration and nutrition and concomitant medications
9. Care of and informational needs of the patient´s family
10. Care for the medical professionals.
2 appendicies adress sedation for prsycological and spiritual distess and d rug selection. The most current draft will be presented for discussion and critique.

PE 1.F153

Thromboprophylaxis in Austrian palliative care inpatient units

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Aim: Palliative care patients are at high risk for venous thrombosis. Subcutaneous injections may diminish quality of life. Guidelines for thromboprophylaxis (TP) in these patients are lacking. We undertook a survey to explore TP practice in Austrian palliative care inpatient units (PCU).
Methods: A questionnaire including six questions about TP was sent to 21 PCUs in Austria. Data were documented for each patient on a certain day in July 2008. 18 (86%) of 21 invited centres included 134 patients.
Results: Mean patient age was 70±15 years, 115 (86%) patients had cancer. 42 (31%) patients had a Karnofsky index (KI) <30 and 103 (77%) were alert and orientated. 63 (47%) patients received low molecular weight heparins in varying dosages. 40% of patients with a KI <30 received TP. In 25 (19%) patients TP had been cancelled at the time of referral to PCU. 29 (22%) patients were involved into the decision of continuing TP, 12 (9%) into cancelling TP. Of the patients involved, 33 (87%) voted for continuing TP, 5 (13%) rejected further TP.
Conclusion: Half of all palliative care patients in Austria receive TP, still 40% of patients with a KI <30 do. Only a minority of patients is involved into decision making on TP but if this is the case, most patients vote for TP.

PE 1.F154

Palliative sedation in patients attends by a home care support team

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Aims: To describe the characteristics of the patients in terminal situation who are sedated in comparison with who are not sedated in our first year of existence.
Methods: Descriptive prospective study.
Measurements: age, Barthel index, Karnofsky, number of visit, chase time, presence of symptoms.
Results: N: 199.Sedation in 41 patients (20% of total sample). Characteristics of the sedated patients: mean age 76 years, mean Barthel index previous 79 and in our first visit 38´5, Karnofsky 44, number of visit 3´7±2´5 in a mean chase time 43 days; presence of symptoms: pain 56%(mean EVA 5´8), dyspnea 32%(mean NYHA 2´9), anorexia 61%, anxiety 44%, depression 37%, insomnia 29%, psychomotricial agitation 14´6%, dementia 19´5%. Characteristics of the no sedated patients (N: 158): mean age 78 years, mean Barthel index previous 68´4 and in our first visit 46´27, Karnofsky 50, number of visit 2´2+/-1´7 in a mean chase time 46 days; presence of symptoms: pain 45%(mean EVA 6´6), dyspnea 29%(mean NYHA 2´5), anorexia 54´5%, anxiety 26´6%, depression 32%, insomnia 36%, psychomotricial agitation 21´5%, dementia 26%.
Conclusions:
1. Patients sedated suffer most functional decline and poor quality of life in our first visit, and this characteristic could be a scoreboard of the necessitate of sedation in terminal patients.
2. Most presence of symptoms in sedated patients but lower perception of pain and dyspnea.
3. Lower chase time in sedated patients but most number of visits in this time.

PE 1.F155

Does a structured end of life-care protocol (Liverpool Care Pathway for the Dying Patient, LCP) improve treatment quality and caregiver morbidity? First results of a prospective semiquantitative survey

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Aim: The LCP is a structured protocol for end of life-care. One goal is to improve interprofessional communication, quality of death and support of informal caregivers. Extensive qualitative research has demonstrated substantial advances in end of live-care by the LCP. However, no data exist on long-term morbidity of bereaved family members in terms of mental health issues (incidence of posttraumatic stress disorder, depression). Therefore, our aim is to document the grade of stress reduction in professionals and the effect on late caregiver morbidity by the LCP.
Methods: Semiquantitative, validated questionnaires for medical/nursing staff (n=55) and relatives of dying patients (n=45) on a general medical impatient unit before implementation of the LCP (July -August 2008). A repeat questionnaire will be handed out in January 2009 to staff members, all relatives undergo a follow-up 6 months after their loved one's death. Data will be evaluated by T-test for unrelated samples and regression analyses.
Results: By October 2008, data are available for staff members only (n=21, 18 nurses, 3 physicians). 70% have a work record of >5 years. At baseline, "inadequate" ordering of diagnostic tests in dying patients and perceived lack of patient information by doctors constitute a major burden for 80% of the nursing staff. Both professions identified incomplete information of family caregivers as a source of ongoing dispute and dissatisfaction in the course of dying and bereavement process. Surprisingly, conflicts arising from hierarchical structures contributed significantly less stressful events.
Conclusion: To maximally reduce unnecessary

stressors, the professional team should be provided a decision tool to ensure a continuous quality of interprofessional and professional-patient communication. As the LCP is designed to meet this need, upcoming trial results are expected to reveal important insights how professionals and relatives cope with the dying process.

PE 1.F156

What do palliative care physicians know about their patients end of life individual preferences?

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Background and aim: A good communication with the physician plays an important role in the patient's awareness process and in his/her preparation to death. It is important for palliative care physicians to know patients' preferences about end of life care and to be able to discuss such matters with the patients themselves. Aim of this study is to estimate the level of knowledge of palliative care physicians about their patients end of life preferences.
Methods: During a training course for the use of the End-of-Life Preferences Interview (ELPI), a novel instrument built to help physicians eliciting patients end of life individual preferences, 23 palliative care physicians were asked to complete the ELPI on the base of the information they obtained through direct discussion with the patient. They were invited to focus on two patients recently followed for at least two months. Whenever a topic had not been discussed with the patient, physicians were told to leave the item missing. The level of knowledge of the physician for each area of ELPI was calculated as the average percentage of non missing answers (NMA) to the items of that area.
Results: The areas in which physicians know more about patients preferences are those related to: information (96% NMA), symptom control (68% NMA), conventional treatments (87% NMA), level of consciousness desired approaching death (68% NMA) and environment and relational aspects of care (93% NMA), while issues concerning the process of "preparation to death" result to be less discussed. In particular physicians have a lower knowledge about what is important for patients to do before dying (51% NMA), about spirituality (54% NMA) and about religiousness (42%NMA).
Conclusion: The results of this study indicate that palliative care physicians discuss with their patients issues regarding the dying process mainly from a medical or pharmacological point of view while issues related to the "preparation to death" are more frequently ignored.

PE 1.F157

End-of-life preferences interview: Eligibility criteria and applicability of a novel instrument

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Background and aim: The capability to make decisions about one´s own dying and death is commonly considered a necessary component of a good death, but difficulties in communicating about imminent death have been documented. Scope of this study is to evaluate the applicability in a palliative care setting of the End-of-Life Preferences Interview (ELPI), developed to help physicians eliciting patients individual preferences concerning the dying process.
Methods: From May to September 2008 18 physicians working in palliative care setting screened all their consecutive cancer patients to evaluate their eligibility for interview administration through the following criteria: age≥ 18 years; expected prognosis ≥ 2 weeks; no strong psychological defences; no severe cognitive impairment; no cultural resistance; awareness of incurability. The ELPI consists of 23 items divided into 2 parts according to the expected level of difficulty in affording the problem: the first level explores preferences about issues regarding the care-giving process, while the second level focuses on preparation for death. Each of the two parts is introduced by key questions aimed at allowing the patient to decide whether and when to stop exploring such sensitive matters.
Results: Of 477 advanced cancer patients screened, 111 (23%) were judged eligible by their own physician. Reasons for ineligibility were the following: unawareness that their disease was incurable (59%), strong psychological defences (32%) expected prognosis < 2 weeks (27%); severe cognitive impairment (25%); cultural resistance to deal with these issues (9%). Of the 111 eligible patients 75 (84%) were proposed to be interviewed, 71 (96%) accepted, and 54 (72%) completed it till the end.
Conclusion: Although not designed as an instrument of wide application in a palliative care population, fact that was confirmed by the limited but expected eligibility rate, ELPI showed a high applicability among eligible patients.

PE 1.F158

Dying in the emergency department

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Background: A large number of patients are admitted to the Emeregency Department (ED) with an acute life threatening illness which is felt to be unsalvageable. A small but significant cohort of these patients cannot be moved elsewhere and thus require end of life care in the ED.
Aim: To critically examine all aspects of end of life care these patients received, and to decide if there is a case for adapting the Liverpool Care Pathway to this setting.
Methods: A retrospective case note analysis of all patients who died in the ED of a district general hospital over a period of six months from June to November 2006, excluding those in whom CPR was attempted.
Results: (To be presented in graphical format in full colour with two case examples described) In total, 16 case notes were analyzed. Median age of patients was 66 years. Average time in the ED from DNAR decision was 4hrs (15mins-21hrs).
Discontinuation of treatment - 86% of patients had IV fluids continued until death, 94% had oxygen continued. In 50% of patients monitoring of observations continued until death. Two patients had blood tests performed following the decision not to continue with aggressive measures, including one patient who had an arterial blood gas taken. All IV medications were discontinued.
Prescribing for the dying phase was erratic and poorly documented - analgesia was only prescribed for 44%, anti-emetic 19%, anti-muscarinic 6%, sedative 25%
Communication with families was excellent but only 25% had spiritual care needs documented.
Conclusion: There appears to be an adequate period of time to allow for holistic assessment and symptom control for patients dying in the ED. Communication and decision making are presently very good. Care could be improved by increasing pro-active prescribing for the dying phase, improved documentation and appropriate treatment withdrawal. These findings support the implementation of an adapted Liverpool Care of the Dying Pathway in the ED.

PE 1.F159

Challenges in end of life care in a palliative care unit in Brazil

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Management of critical oncological patients in the last 48 hours of life is defined in literature as End of Life Care (ELC). At this point, the aim is to provide comfort to both patients and caregivers, avoiding dysthanasia, irrational use of resources, and therapeutic futilities such as artificial hydration, alternative nutritional pathway, antibiotic therapy, blood transfusion. Adequate management of those patients included also palliative sedation for those who presented refractory symptoms.
In our study, we observed those patients, under ELC, who deceased in our Palliative Care unit from January 2007 to August 2008. During the period, the monthly average admissions in our facilities were 164 with a global mortality rate of 65%, per month. However, considering exclusively patients under ELC, the mortality rate was 24% per month. The average of patients submitted to blood transfusion was 5.2%, taking into consideration all inpatients, and not only ELC patients. Palliative sedation was implemented in 76 (3,2%) of total patients studied. The more frequent refractory symptom observed among those patients was dyspinea, which resulted in palliative sedation (55% of all sedated patients). Antibiotics administration is formally contraindicated in ELC patients. In the population analyzed, 16.9% of patients were receiving antibiotics in the last 48h of life. With the main purpose of improving ELC, discussions have been carried out in our Palliative Care Unit engaging all health professional team along with regular meetings with the caregivers to make out the best approach in each case.
Conclusion: It is crucial to make a distinction between patients under Palliative Care and patients under ELC. The last group has exceptional needs which oblige to a distinctive handling. Health professionals who deal with these patients in a regular basis should be skilled not only in relieving patients' symptoms but also in comforting their families.

PE 1.F160

Changed patterns in palliative sedation practice after the introduction of a national guideline

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Background: Continuous sedation, contrary to euthanasia, has been increasingly accepted among medical professionals. In the Netherlands, a national guideline for (continuous) palliative sedation has been developed to contribute to the quality of palliative sedation practice. The present follow up study investigated whether the practice of continuous sedation has changed after the introduction of this guideline.
Methods: This study compared the practice of continuous sedation before and after the introduction of the guideline in December 2005. Physicians were asked to report on their last case of deep and continuous sedation in the past 12 months.
Results: The response rate of the second measurement was 69.3% (n=341). Of these physicians, 160 reported a last case of continuous sedation both in the baseline and in the follow up study. Physicians reported a significant increase in patient involvement in decision-making, from 72.3% to 82.2%. Pain remained the most dominant reason to start sedation while exhaustion as a reason for sedation increased. The use of benzodiazepines increased from 69.9% to 90.4%. Artificial hydration was more often forgone in 2007 compared to the first period (78.8% vs. 56.3%). Also, symptom directed treatment was often forgone during sedation.
Conclusion: After the introduction of the guideline, physicians reported a number changes in palliative sedation practice conform the recommendations of this guideline. Nevertheless, future questions to be solved concern the right indication for sedation and the need for symptom directed treatment during sedation.

PE 1.F161

Continuous deep sedation: Nurses' involvement in decision-making

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Research aims: Continuous deep sedation (CDS), i.e. using medication to induce unconsciousness until death is an important topic of medical and ethical debate. Nurses are highly involved in carrying out this practice. We aimed to investigate nurses' involvement in the decision-making process in CDS on a nationwide level.
Methods: We performed a questionnaire survey among 1709 nurses who reported to have been involved in medical end-of-life decisions in Flanders, Belgium in 2007. Nurses were asked to recall their most recent patient who had died preceded by an end-of-life decision, including CDS. Questions were asked about the taken decisions and their role in it.
Results: Response rate was 76% (N=1167). CDS was reported in 253 cases. Communication between the physician and the nurse about the decision occurred in 82% of cases. Before making a decision, physicians

asked nurses for information about the patient's condition (53%) and relatives' opinions (44%). In 38% of cases nurses informed the physician about the patient's condition on their own initiative. In 28% of cases the physician had taken the decision in consultation with the nurse. The nurse initiated the discussion about CDS in 9% of cases. Communication between nurses and patients or relatives occurred in respectively 26% and 76% of cases, mostly about their wishes about CDS (respectively 68% and 67% of cases). For both patients and relatives, about 40% expressed their wishes to the nurse before expressing it to the physician.
Conclusions: Communication between physicians and nurses and between nurses and relatives is common in decisions on continuous deep sedation. Physicians consider nurses as experts on the patient's condition. Patients and relatives consider nurses as companions to talk to. Nurses act as essential informants and intermediaries, and sometimes consultants in decision-making of continuous deep sedation.
Source of funding: Fund for Scientific Research, Flanders.

PE 1.F162

Metropolitan versus nonmetropolitan variation in place of death in Belgium, the Netherlands and England

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Aim: Place of death is considered an indicator of good end-of-life care, with home death preferred by most terminally ill patients. Previous research suggests substantially more hospital death and less home death in the metropolitan versus non-metropolitan regions of Europe. This study therefore examines metropolitan versus nonmetropolitan variation in place of death in Belgium, the Netherlands and England.
Methods: Death certificate data of all deaths in 2003 were linked to census data. Place of death of those dying of 7 conditions likely to benefit from palliative care (cancer, heart/renal/liver failure, respiratory/neurodegenerative disease, HIV/AIDs) living in 6 English, 3 Dutch and 2 Belgian metropolitan regions was compared to that of nonmetropolitan residents. When examining differences in place of death (home vs. hospital; care home vs. hospital), multivariate analysis was used to control for possible confounders: cause of death, sex, age, income, social support, and available hospital and care home beds.
Results: Those living in metropolitan regions less often died at home and more often in hospitals, compared to nonmetropolitan patients. In Belgium and the Netherlands they also more often died in care homes. Multivariate logistic regression analyses showed that, even after controlling for possible confounders, those in nonmetropolitan regions were more likely to die at home and less likely to die in hospitals than those in metropolitan regions (OR: Eng:1.26; NL:1.49; B:1.74). In England, those in metropolitan regions were more likely to die in hospital and less likely to die in a care home than nonmetropolitan residents.
Discussion: Dying in Europe's metropolitan regions is less likely to occur at home and more likely to occur in hospital than in nonmetropolitan regions. This inequality could point at a different end-of-life care in metropolitan regions, and suggests the need for a metropolitan approach to end-of-life care in all care settings.

PE 1.F163

Expectations about and impact of the Liverpool Care Pathway for the dying patient (LCP) in an Italian hospital

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The study is aimed at exploring the expectations and the impact on healthcare staff of the LCP in an Italian hospital. It is part of the project "Implementation and assessment of the Italian version of the 'Liverpool Care Pathways for the Dying Patient' (LCP-I)", with the objective of evaluating the feasibility of LCP implementation in Italian hospitals. Qualitative information derived from four Focus Group Meetings (FGMs) which were separately carried out with six physicians and nine nurses working at the general medicine ward of an italian hospital before the beginning and after the end of the implementation process. Eligible participants were sampled stratifying by age, sex and work team. Interview topics concerned end-of-life care related problems, expectations about and impact of the LCP program. Tape recordings of the focus groups were transcribed verbatim, and the transcripts analyzed independently by two research psychologists using thematic content analysis.
Five topics were identified: pain management and discontinuing inappropriate treatments, communication with patients, relatives and between professionals, practical issues. As compared to those reported in the first FGMs, responses from the final FGMs evidenced physicians feel themselves more confident with pain management and with discontinuing inappropriate treatments, and they were more inclined to recognize the value of nurses' work. Nurses highlightened advantages in using PRN medication, but stressed lack of personnel and time as obstacles to really improve end-of-life care. All participants seemed to become more aware of their own difficulties in communication tasks and, paradoxically, more unsure about their own ability in supporting and informing the dying patient and his/her family.
LCP-I implementation can improve either knowledge about physical symptoms management, and professional awareness of the problems related to emotional and informative support in end-of-life care.

PE 1.F164

Dying of cancer in Sweden - Report from the Swedish Palliative Register 2007

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Aim: To describe quality indicators of cancer deaths based on the Swedish palliative register.
Methods: The "Swedish Palliative Register" is a nationwide quality register for the improvement of end of life care. The aim of the register is to register and report quality indicators related to care during the last week of life for all expected deaths in Sweden. The register started in 2005. All health and community based care services were invited to use the register. All registrations were made on line according to ethical and legal requirements. Death registrations for 2007 including patients with cancer as a main diagnosis were selected for analysis.
Results: The total number of cancer related deaths in the register was 6 602. The range of cancer deaths was 5 - 57 % of the total number of cancer deaths in the county. Cancer patients were older and had longer care when cared for in community based care facilities than in specialised palliative care or in acute care hospitals. Almost 50% of the patients in specialised palliative care were reported to be without any symptoms during the last week of life. In acute care hospitals and in short or long term community care the number of patients without symptoms the last week of life was 26%, 44% and 55%, respectively. Drugs were prescribed on demand for pain, anxiety, respiratory tract secretions and nausea for a majority of patients in palliative care but to a lesser extent to other patients. Only 15% of all dying patients with cognitive ability to assess pain with a VAS/NRS scale had done so.
Discussion: The quality of end of life care varies between different types of care. While about 1/4 of the yearly deaths in Sweden are caused by cancer only a minority have access to specialised palliative care. On the other hand, in specialised palliative care about 90% of the patients have cancer. A further increase of registrations in the Swedish palliative register will provide more robust data on inequities of end of life care.

PE 1.F165

Quality at the end of life - Report from the Swedish Palliative Register 2007

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Aim: To describe quality indicators of end of life care based on the Swedish palliative register.
Methods: The "Swedish Palliative Register" is a nationwide quality register for the improvement of end of life care. The aim of the register is to register and report quality indicators related to care during the last week of life for all expected deaths in Sweden. The register started in 2005. All health and community based care services were invited to use the register. All registrations were made on line according to ethical and legal requirements.
Results: The total number of registered deaths in the register was 9 903. This is just above 10% of the total number of deaths in Sweden in 2007. Compared to 2006 this is a 100% increase. The increase in registration differed between different counties, e.g. Kronoberg 0.8-8% of all deaths and for Örebro 0-7.4%. 53% of all registrations were made through specialised palliative care units/teams. 30% of registrations were performed in community care homes and about 15% through hospital wards.
Discussion: The number of registrations is increasing year by year form the start in 2005. In some counties only few percent of deaths are included, in other counties 1/3 of all deaths. The low number of registrations may reflect less availability of palliative care.

PE 1.F166

Constructing dying and death; An ethnographic account of the last months of life of cancer patients

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Aims: This study concerns with the experience of care and illness of patients with advanced cancer in Greece. It also aims to understand the dying process as it is constructed over time, by following patients, families and health professionals involved in their care, until patients' death.
Methods: The study adopted a qualitative approach, employing ethnography as it is methodological framework. Over a period of 18 months each patient was followed over time as they came in contact with the hospital and other health care services. Fourteen patients, their family members, nurses and doctors involved in patients´ care (eighty two participants in total) were observed (830 hours of participant observation) and interviewed (20 formal and more than 50 informal discussions) throughout this period.
Results: Patients experience of their illness and care during their last months of life was influenced by their own personality style and the meaning they attached to their experience. Family relationships, as well as interactions with health professionals were proved to be critical in the decision making during their last months of life. Dying processes were equally influenced by the health care context and the provision of care offered throughout their journey. All these parameters shaped patients' attitudes towards their dying and their preferences over care and place of death.
Conclusion: Dying processes and patients' experiences of their illness and care are constructed over time by the patients themselves, their interactions with those involved in their care and the broader context in which this experience is taking place. Such aspects should be taken into consideration when planning for palliative care services, sensitive to patients' needs in the particular cultural contexts where they live and die.

PE 1.F167

Are levels of comfort (as documented on the Liverpool Care Pathway for the dying patient - LCP) in the last 24 hours of life comparable for both cancer and non cancer patients?

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Aim: The aim of this presentation is to use data collected as part of the first National Care of the Dying Audit in Hospitals in England to compare documented levels of comfort for patients with a diagnosis of cancer and those with a non-cancer diagnosis. This audit was carried out by the Marie Curie Palliative Care Institute Liverpool in collaboration with the Royal College of Physicians using data collected for patients whose care in the last days of life was delivered using the LCP.
Method: 118 Hospitals contributed data from LCPs for up to 30 patients (2672 total) who died within a 3 month period. The sample was then split into 2 groups: Group 1 (cancer) and Group 2 (non-cancer). Descriptive comparisons were undertaken in levels of comfort (for Pain, Agitation, Respiratory Tract Secretions, Nausea & Vomiting, & Dyspnoea) as documented on the LCP 4 hourly in the last 24 hours of life.
Results: Group 1 (cancer) accounted for 45% of the sample and Group 2 (non cancer) for 55%. A high proportion of Group 2 patients had Stroke, heart failure, dementia, or chronic renal failure. Documented levels of patient comfort for all symptoms were comparable between groups. For example, the 4 hourly assessments of pain showed that Group 1 patients were not comfortable in only 5% of documented assessments and Group 2 patients in only 3% of documented assessments. However, the amount of assessments not documented (missing data) were relatively high for both groups (17% & 20% respectively).
Conclusions: The high % of patients with a non-cancer diagnosis in this sample illustrates that the LCP is used in these hospitals for patients regardless of diagnosis. The results also suggest that patient comfort in the last 24 hours of life are high in both groups. The relatively high levels of assessments not documented is a concern for both groups. These preliminary results will be discussed in terms of the methodological approach taken and the need for future research.

PE 1.F168

Attitudes of Austrian patients with malignancies towards writing advance directievs

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Aim: Advanced care directives (AD) are intended to preserve autonomy of patients at the end of their life. We therefore investigated attitudes towards AD in hospitalized patients with malignancies in a prospective controlled study.
Methods: All patients were consecutively approached and were informed about the features of AD in a standardized manner by a single independent physician. One hundred eight (39 female, 69 male; age:56.6±14.9 years) out of 140 patients who were invited, completed the study.
Results: Among these, 5% (5/108) already had an AD and 85% (92/108) did not want to make one. "Full trust in physicians" (22%) and "not important for me at the moment" (15%) were the most prevalent reasons for denying the need of AD. Only 10% (11/108) of patients decided to make an AD. Their decision was not found to be interrelated with a specific diagnosis nor with a panel of socio-demographic variables. Patients who decided for an AD were significantly more depressive than patients who decided against it (HADS-D: 8.3±5.0 vs.5.8±4.1; p= 0.035). Their HADS depression score was negatively associated with their Karnovsky index (r=-0.232, p=0.017).
Conclusions: Our data show that demand for AD is low in our population of hospitalized cancer patients and is associated with a high depression score and a low performance status.

PE 1.F169

"Vigil views" - Impact of using care of the dying pathway in acute hospital setting

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Background: With the release of the End of Life Strategy in July 2008, End of life care is receiving more emphasis. Use Of the End of Life tools, including The Liverpool Care Pathway (LCP), or equivalent, is increasing across all healthcare settings and not just within specialist palliative care services.
There have been studies looking at the impact of the LCP on staff in the hospice setting and nurses with an interest in palliative care, but there is limited information on the views of non-palliative care staff. This study, looked at the views of clinical staff on the impact of the use of a care of the dying pathway (Vigil pathway) on patients, their carers and staff in the acute hospital setting.
Method: The study had a mixed methodological approach, using both qualitative and quantitative methods involving 2 phases and had local ethical and R+D approval.
Phase one: Semi- structured interviews of a purposive sample of 12-15 non-palliative care nursing and medical staff across all grades and specialities was undertaken. The responses were recorded and analysed and emergent themes sought.
Phase two: Involved a questionnaire, sent to all doctors in training grades, within the hospital. The questionnaire explored emergent themes from phase one.
Results: This poster displays the results of both phases and demonstrates the views of non-palliative care staff who use the pathway and how this information will be used to inform future education programmes.

PE 1.F170

Assessing the impact of an LCP Facilitator using data from the National Care of the Dying Audit Hospitals England (NCDAH)

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The aim of this work is to use data collected in the first National Care of the Dying Audit in Hospitals in England involving 2672 patients whose care in the final days of life was delivered using the Liverpool Care Pathway for the Dying Patient (LCP). The data is used to explore levels of documentation and outcomes for two patient groups - those in hospitals with an LCP Facilitator and those in hospitals without - as a designated person providing training, education and ongoing support is deemed important for success.
Method: This work focuses on 50 hospitals that submitted the full sample of 30 cases (n=1500). The sample was split into 2 groups.
Group 1: Hospitals with an LCP facilitator;
Group 2: Hospitals without.
Descriptive comparisons were undertaken to assess:
(1) the number of 4 hourly assessments (for Pain, Agitation, Respiratory Tract Secretions, Nausea & Vomiting & Dyspnoea) not documented in the last 24 hours of life, and
(2) for those that were documented, the reported level of absence of these symptoms for patients in this period.
Results: For Group 1 the number of assessments not documented for all symptoms assessed were lower - e.g. for Pain the proportion in Group 1 was 15.9%, compared with 25.4% in Group 2. For those 4 hourly assessments that were documented, the level of reported patient freedom from pain was similarly high (Group 1, 95%; Group 2, 96%).
Conclusions: These preliminary results suggest that higher compliance with the document for the assessment of these symptoms is more likely when an LCP facilitator is present, though the level of comfort for documented assessments is similar. However, the fact that almost one quarter of all required assessments were missing for Group 2 is of concern and should be taken into account when interpreting these results. These results and the results of further planned analyses will be discussed in terms of the methodological approach taken and their relevance to future research.

PE 1.F171

Are patients who die at home any different?

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To assess if the characteristics of the patients who died at home were different from those who died elsewhere. Retrospective study, analyzed patients followed from 8/2006 to 8/2008 that died: demographic data from patient and carer, pathology, symptoms. Statistical analysis was performed using Chi-Square and one-way ANOVA.
Identified 77 patients that died: age 69±13, male 54,5% (n=42), median Palliative Performance Score (PPS) on admittance 40. The most frequent primaries were lung 18% (n=14), head and neck 17% (n=13) and digestive 17% (n=13); 78% (n=60) were metastatic. Patients were followed by the our team 78±150 days (0-1028). The carers: aged 58±14, female 80% (n=61), male 20% (n=15), one patient had no carer. The most frequent carer/patient relationship was spouses 47% (n=36) and descendants 26% (n=20). Sixty-nine percent of the carers (n=53) received help from other family members. Place of death: 48% (n=37) patients died at home, 42% (n=32) at our hospital and 10% (n=8) in other institutions. When compared, those who died at home with those who died elsewhere (gender, topography of primary, carer gender, patient/carer relationship, help from other family members, presence of delirium or dyspnea, age of patient, carer age, PPS on admittance, days on charge of the team) only gender of the patient and PPS reached statistical significance. Carer gender approached significance (p=0.06).
Our study has the limitations of being retrospective and having a small number of patients. Being a man, with a low PPS on admittance and possibly being cared by a woman were factors associated with death at home.

PE 1.F172

Refraining from blood product substitution in patients with far advanced haematological malignancies - Case series and conceptual framework

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Introduction: In patients with haematological malignancies, substitution of blood components may be an integral part throughout the course of the disease, as bone marrow failure is a sequel of chemotherapy and the disease itself. Continuing substitution of blood has been postulated a relevant problem in referring patients to palliative care (PC) services, even in far advanced disease. In PC, clear concepts for questioning or restricting transfusions, in order to avoid medical futility at the end of life, have not been defined.
Methods: Within two years, all patients with haematological malignancies contacted by our PC services were retrospectively analyzed with regard to intended or accomplished transfusion restriction processes. A conceptual framework is described, based on repeating patterns of medical and psychosocial decision criteria.
Results: 40 patients with underlying haematological malignancy were enrolled in our PC services. In 23 of those, procedural aspects of blood product substitution were discussed. Criteria to question ongoing substitution were far advanced disease, absence of subjective transfusion benefit, or possible interference with the patients´ priorities like being cared for a home despite being unfit for transportation. Conceptual patterns in a PC approach comprised an assessment of previous transfusion requirements / degree of bone marrow failure, logistic expenditures, redefining symptom guided transfusion criteria, determining the subjective net benefit by a given transfusion, prioritizing the patients´ wishes, using transfusion related questions to address further end of life aspects and explaining and preparing for bleeding crises.
Discussion: This case series demonstrates that PC services can provide substantial conceptual support for reassessing transfusion needs in patients with far advanced haematological malignancy, taking into account not only clinical and disease specific, but also psychosocial aspects and individual values.

PE 1.F173

Reversal of increasing trends in hospital deaths is associated with development of hospice home care services

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Background: In developed countries including Singapore, increasing numbers of people are dying in hospital while fewer people end up dying at home. Hospice home care services have developed over the past 20 years in Singapore. These services covered largely people suffering from cancer, 99.5% in 1990 and 92% in 2006. The number of non-cancer patients served by the hospice services is only beginning to increase in recent years.
Objective: To examine the impact of the development of hospice home care services on the place of death in people dying of cancer as compared to other diseases.
Methods: Trends in place of death for people aged 65 and above were examined for 3 major disease categories: cancer (ICD-9:140-208), heart disease (ICD-9:390-429) and lung disease (ICD-9:460-519) for the years 1990 to 2006. Data from the largest hospice home care service in Singapore, accounting for 80 to 90% of patients, were also collected for this period. Data on diagnosis, place of death and length of stay under the service were also collated.
Results: People dying of heart disease and lung disease showed a rising trend in hospital deaths from 1990 to 2006. The proportion of elderly patients dying in hospital rose from 48.2% in 1990 to 63.2% in 2006 for heart disease, and from 45.7% to 68% for lung disease, respectively. However, cancer deaths showed the opposite trend, decreasing from 55% of cancer patients dying in hospital in 1990 to 44% in 2006. Over the same period, the number of patients dying of cancer seen by hospice home care services increased from 5.8 % of total cancer deaths in 1990 to 53.1% in 2006. The median length of patient contact with the hospice home care services also increased from 13 days in 1990 to 39 days in 2006.
Conclusion: Development of hospice home care services for cancer patients is associated with a reversal of trend towards hospital deaths in Singapore and had enabled more cancer patients to die at home as opposed to non cancer patients.

PE 1.F174

A survey of in-patient care of St Lazarus Hospice in Krakow, Poland in the years 2000-2007

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Hospice 30-bed ward was opened in 1996 in Kraków, district town of approx.800 000 inhabitants. In the years 2000-2007 there were 2352 patients admitted (from 294 to 370 per year). Age ranged between 15-102 years (mean 69),51% had been sent from hospitals. 86% patients died in the ward and about 11% were discharged for further care at home. 91% of patients were diagnosed with cancer, (mostly lung (449), breast (197), brain (137), colon (117), stomach (95) and cervix uteri (81) which was incoherent with death rate in Krakow population. Among 206 (9%) of non-cancer patients, the most common recognitions were atherosclerosis (74), cerebral infarction (13), multiple sclerosis (10), congestive lymphatic failure (8), ischaemic myocardial disease (7) and chronic heart failure (6). The average awaiting time for admission was 6 days, and mean time of residence 27 days (from 1 to 701 days),both with decreasing tendency in recent years. Medium occupation of beds widened from 75% to 88%. Patients' the most common problems noted were fatigue 89%, somnolence 76%, pain 73%, loss of appetite 66%, general discomfort 52%, depression 39%, constipation 34%, dyspnea 32% and pressure sores 26%. Drugs most often used were anxiety-relieving/hypnotics (60% of admitted patients), Morphine (55%), steroids (52%) miorelaxants (45%) Haloperidol (40%), antibiotics (40%) Tramadol (38%) and detergent laxatives (38%). There were 987 patients (42%) parenterally hydratated (mostly subcutaneusly). Average survival time among patients who received antibiotics was 44 days (in group not taking antibiotics 14,6 days) and among parenterally hydratated was 31,42 days (patients without hydratation 24%). More than a half of admitted required analgetics; Morphine-55% patients, Tramadol- 38%; Paracetamol- 36%; NSAIDs- 24%; Fentanyl - 23%; Ketamine - 7% and Methadon - 3%. 375 patients (16%) received various forms of physiotherapy. This data shows that our hospice was a valuable complement to the hospice home care.

PE 1.F175

Study about the knowledge and use main caregivers of advanced cancer patients have of the advanced directives (AD) in the oncology palliative care service

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Introduction: Professionals who practice palliative care face daily different kinds of ethical problems. Under these circumstances the document of advance directives (AD) is considered as a useful instrument in the making decision process in these difficult situations. To discuss the execution of the AD with a patient in an advanced-terminal phase has been considered harming for the patient since it involves facing him with a real situation such as death. There is scarce data about AD in the field of Palliative Care to confirm this statement.
Aim: To determine the number of main caregivers of advanced cancer patients who know the AD and their opinion about the impact it produces on the patient to inform him about the existence of AD.
Methods: Main caregivers were surveyed whether related to the patients or not. They were asked about their knowledge of AD, source, desire to know AD, and if they consider it useful or invasive to inform the patients about the AD. If the answer was invasive the reasons were stated.
Results: 64 caregivers were interviewed. 73.4% of the relatives don't know about AD although 72.3% showed interest. 49.2% considered it would not interest the patient. 48.4% thought the patient could be bothered if informed about AD. Main reasons:
1) to talk about AD states clearly the topic of death,
2) previous feelings of rejection to talk about the illness and the possibility of dying,
3) family's protection.
Conclusion: It is necessary to improve the policies of diffusion and information of AD in our centre. It would be appropriate to develop a study about the impression patients have when informed about AD.

PE 1.F176

An examination of end of life care in a Canadian long term care home using the Canadian Hospice Palliative Care Association norms of practice

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The Canadian Hospice Palliative Care Association (CHPCA) has developed Norms of Practice to guide the provision of quality palliative care in all care settings where people die an expected death. These Norms address issues of disease management, physical, psychological, social, spiritual, practical, end of life/death management, loss and grief. They also outline the processes for providing care and the organizational context needed to support quality palliative care. While long term care (LTC) homes are a major site of death for elderly people in Canada, little research has focused on examining the delivery of end of life care for residents in long term care homes using the CHPCA Norms as a framework for analysis.
Aim: To examine LTC staff and family members´ understanding and experiences of hospice palliative care in a LTC home using the CHPCA Norms of Practice as a framework for analysis.
Methods: A focused ethnography was conducted in a 110 bed accredited long term care home in Ontario, Canada that experienced 18 resident deaths in the previous year. Over the course of four days of intensive field work, 98 people were interviewed individually or in focus groups. Participants included administrators, physicians, nurses, personal support workers, spiritual care/life enrichment workers and residents´ families. Interviews were audiotaped, transcribed and analysed to identify core themes in relation to the CHPCA Norms of Practice.
Results: All participants identified the importance of comfort at the end of life and were committed to providing a good death for residents. However, the philosophy and scope of issues included in the CHPCA palliative care norms were not understood by most participants. Resources and education were lacking to address psycho-social issues. Disease mangement and physical care were the primary focus.
Conclusion: The CHPCA Norms provided a useful framework to identify the scope of end of life care and identify gaps in a LTC home.

PE 1.F177

Do German physicians feel comfortable with advance directives?

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Aim: Up to now advance directives have not been laid down by law in Germany. Therefore uncertainties are common among physicians and patients how to deal with these documents. We performed a survey concerning the knowledge, experiences and attitudes of physicians on advance directives. The evaluation can encourage the discussion about the necessity of a legal regulation.
Methods: A questionnaire consisting of 21 questions on advance directives was dispatched to 600 randomly selected physicians in clinics und private practices in Mecklenburg-Western Pomerania with the support of the Board of Physicians in April 2008. 35% (n=207) have been returned until today.
Results: Two thirds of the physicians feel insufficiently informed about advanced directives and the recommendations of the Federal Board of Physicians on this topic. Almost all physicians consider a living will as important to determine the presumed wishes of the patient who is not able to give an informed consent. But only a half of the physicians find it useful in the daily work. More than 80% refuse that there should be an obligation for every patient to draw up an advance directive. The predominant majority is interested in professional training on medical decision making and advance directives.
Conclusion: It would be helpful to implement advance directives into the German Civil Law to avoid further uncertainties. Examples exist in Australia, Austria or France. This would help people who drew up their living will to have their autonomy being respected. But the advance directive should remain a voluntary instrument for the patients.

PE 1.F178

Care of the dying: The last 72 hour of life

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Introduction: End of life care is an integral part of oncological treatment. A key issue to appropriate care is diagnosing dying. However, predictive signs of upcoming death are often not recognized. For that reason inappropriate procedures and irrelevant drugs are introduced.
Aim: To evaluate care of a dying patients (pts) in Department of Palliative care (DPC), Department of Medical Oncology (DMO) and Department of Radiation Oncology (DRO). Our questionnaire was designed to highlight three main topics: recognition of a dying process; changes in treatment decision; and influences of Liverpool Care of the Dying Pathway (LCP) introduction.
Material and methods: We analyzed medical documentation of 139 pts with solid tumor who have died during hospitalization from January 2007 till June 2008. We have registered any written note of dying signs according to LCP, use of LCP, symptom management and drugs being used in last 72 hours of life.
Results: Average age of pts was 62.4 years. At least one sign of upcoming death was found in 42.4% of medical documentation (71.0% DPC, 45.0% DMO, 27.9% DRO). LCP was used in 7.2% (32.3% DPC, 0% DMO and DRO). 6 pts (4.3%) received transfusion (0% DPC, 5.0% DMO, 5.9% DRO), 11 pts (7.9%) received parenteral nutrition (7.5% DPC, 12.5% DMO, 7.4% DRO), 85pts (61,2%) parenteral hydration (35.5% DPC, 65.0% DMO, 70.6%

DRO). Laxatives were administered to 44 pts (31.7% total, 35.5 DPC, 30.0% DMO, 30.9% DRO), corticosteroids to 66 pts (47.5% total, 29.0% DPC, 45.0% DMO, 57.4% DRO), antibiotics to 46 pts (33.1% total, 19.4% DPC, 27.5% DMO, 42.6% DRO) and diuretics to 40 pts (28.8% total, 9.7% DPC, 35.0% DMO, 33.8% DRO).
Conclusion: Our results revealed important differences in recognizing and registering upcoming death between our departments and consecutive differences in appropriate decision. According to our results introduction of LCP (in DPC) improve approach to a dying patient.

PE 1.F179

Changing the culture - Reversing the trend in place of death

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Background: Five years ago in 2003 the trend for place of death was that of increasing hospital deaths and decreasing home deaths despite increased education for all healthcare professionals and slowly increasing use of two of the End of Life Tools, the Vigil Pathway (Liverpool Care Pathway) and the Gold Standards Framework (for palliative care in primary care).
Method: Although a certain amount of education was already being provided to all healthcare professionals in all healthcare settings it clearly was not having the desired effect of ensuring that the trend for decreasing home deaths and increasing hospital deaths were reversed to match the desire of patients. An educational explosion by all members of the palliative care service was required to change the culture across all healthcare settings and was subsequently undertaken.
Results: By the end of 2008 this educational initiative and use of these tools has reversed the trend in place of death and we are now seeing an increase in home deaths, a reduction in hospital deaths and a critical mass of healthcare staff having received palliative care education.
Conclusion: This poster displays the detail of the educational initiatives and the numbers of health professionals who had been reached, along with the use of the Vigil Pathway across all healthcare settings, the changes in place of deaths figures and the uptake of the Gold Standards Framework.

PE 1.F180

Prescribing in pink! Development of a specific 'end of life' hospital inpatient prescription sheet

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Background: Following an audit of the timeliness of prescribing of 'as required' drugs for the symptoms at end of life which had been undertaken in a specialist palliative care unit (SPCU), community and acute hospital setting, it was clear that timeliness of prescribing was less certain in the community and acute hospital setting than in the SPCU.(Whitfield et al 2007) Preprinted labels, for sticking on to community drug administration sheets, were already being piloted successfully in the community and were included in Vigil Pathway (Liverpool Care Pathway) packs for the community setting and it was suggested that a similar preprinted sticky label which could be stuck on to hospital drug sheets might be made available to be included with Vigil Pathway packs for the hospital.
Method: This suggestion was discussed at the acute hospital Nursing and Midwifery Advisory Group (NMAG) when concerns were raised at the possible mishaps which might occur if the labels were not used correctly e.g. signed by prescriber before being stuck onto the patient's drug sheet, stuck on to the wrong drug sheet etc. A new suggestion was made that producing a new hospital inpatient prescription sheet the same colour as the Vigil Pathway document (pink) would both differentiate it from the current hospital drug sheets (blue), and ensure that only the drugs considered necessary to be continued were then prescribed along with the 'as required' drugs since the new sheet would have to be rewritten. This suggestion was acceptable to the NMAG and the Drugs and Therapeutics Committee and printed. A further audit of timeliness was then undertaken to see whether improvement had been made.
Results: This poster shows the new prescription sheet compared to the standard one, and displays the results of the second audit, post introduction of the new system, compared to the first audit.

PE 1.F181

Overcoming barriers to improve end of life care in developmentally disabled adults residing in group homes in North Sydney

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Advanced medical technology has progressively resulted in an increase in life expectancy of the general population, which includes developmentally disabled adults (RN, 2007). Palliative care in many ways has enhanced the quality in end of life care of terminally ill patients, but adults with developmental disability have not yet encompassed the benefits to the same extent (Centre to Advance Palliative Care, 2000). This maybe due to their minority status of just 0.8% in the general Australian population (Australian Bureau of Statistics, 2006), making them comparatively invisible to the society at large and to the HealthCare services. This paper will focus on some of the many complex issues faced by developmentally delayed adults ensuing in potential obstacles towards the achievement of efficient and cost effective quality of life in terminal phase of their illness. Most common are communication barriers effecting provision of care to patients and families which can result in lack of coordination and continuity of care (Kingsbury, 2005). In addition, ethical dilemmas with over/under use in provision of care could result in potential abuse and neglect as well as unwanted physical and emotional distress to the patient/ family and the interdisciplinary team. Two case studies will be presented to highlight the significance of forwarding timely referrals to the palliative care team.
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PE 1.F182

Indications for palliative medicine consultations in the emergency department - A retrospective case series

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Although hospice and palliative medicine is the fifth and newest subspecialty approved by the American Board of Emergency Medicine, there is no published data on the indications for and treatments employed by palliative medicine consultations (PMC) in emergency departments (ED). In this study we characterize patients receiving PMC and report indications for consultation and patient outcomes.
This was a retrospective case series. This study was performed in a large urban ED. Cases were identified using the inpatient hospice and palliative medicine database. Included were patients that received a PMC in the ED. Patients were excluded if they expired prior to initiation of the consultation.
During the study period, 44 patients received PMC and 38 of these had available data. The mean age of the patients was 76 years (range 43-100 years, standard deviation (SD) 16.2), 61% women; 68% African American, 24% Caucasian, 8% other. The most common clinical presentations were 45% altered mental status, 39% dyspnea, and 8% weakness. Terminal diagnoses were identified as 34% cancer, 26% dementia, 18% organ failure, and 22% other. 29% (95% confidence interval (CI) 15%-43%) of patients presented with an advanced directive. Indications for PCC in the ED and their frequency were: discussions of goals of care-100%; determination of "Do Not Resuscitate (DNR)" code status-84% (95% CI 73%-96%); pain management recommendations-79% (95% CI 66%-92%); admission to palliative care service-87% (95% CI 76%-98%). 71% of patients expired in the hospital and 29% were discharged. Mean length of stay was 2.66 days (median 2 days, SD 2.28).
Patients receiving PMC in the ED presented with non-cancer diagnoses in approximately two-thirds of cases. Although requested infrequently, PMC were associated with high rates of DNR orders and admissions to the palliative service and short lengths of hospital stay. Prospective studies are needed to determine the need for and benefits of PMC in the ED.

PE 1.F183

Evolution of opiate use in two hospitals of Madrid (Spain) between 2002 and 2006

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Aim: Describe the evolution of prescription opioids from 2002 to 2006 in two hospitals of Madrid in Spain (Hospitales Universitarios de la Princesa y la Paz).
Methods: A retrospective observational study of prescriptions made by calculating Defined Daily Doses (D.D.D.) per million inhabitants.
Results: In the studied hospitals, the most prescribed opioid of the third step of the WHO analgesic ladder is the transdermal fentanyl (5.61 D.D.D. in 2006 in Hospital Universitario de la Paz and 3.51 D.D.D. in the Hospital Universitario de la Princesa), followed by morphine (4.49 and 29.54 but this last data is masked by the figures of the Pain Unit and Anesthesiology) and meperidine (0.44 and 0.13).
Conclusion: Our data reflect the increase in consumption of opioids, despite declining morphine. It is noteworthy that transdermal fentanyl is the largest opioid prescribed.

PE 1.F184

Survival of patients referred to a palliative care service in Sheffield, England

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Background: It is important to define patients with a short prognosis in order to facilitate service planning and allow patients and their families to plan for the future. The evidence is that physicians are poor at predicting survival. Part of the difficulty is that however good the prediction is, individual survival is a probabilistic event. Examining the features of a population with regard to its survival may help better planning.
Aim: To analyse features of a population referred to Palliative Care Services in order to better describe individual probability of survival.
Method: Service evaluation involving analysis of data from referrals made to Palliative Care services at the Northern General Hospital in Sheffield between 7/5/2002 and 29/3/2007. Patient variables included demographic data and diagnosis while the dependent variable was survival from first referral to the service. Data was analysed using SPSS for Windows 14.0 to produce Kaplan-Meier survival curves and compare differences in median survival.
Results: 75.6% of the 3586 new referrals had a cancer diagnosis. These had a median survival of 17 days, significantly longer than non-cancer patients at 5 days ($p<0.001$). Other factors that were associated with better prognosis included age and female gender and diagnosis ($p<0.001$). 32% were dead within a week of referral, but 9.4% were still alive at 180 days.
Conclusions: Although for many of our patients survival is short, their risk of dying decreases with time. This variation need to be accommodated in clinical services for end of life care.

PE 1.F185

Home Care Support Team in Barbastro at the first year of activity

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Aims: To describe the activity of the Home Care Support Team (HCST) of Barbastro (Spain) and the characteristics of the patients at the first year of activity.
Methods: Descriptive prospective study.
Measurements: age, sex, principal caregiver, Barthel, Karnofsky, patients derivation, derivation motive, end attention motive, symptoms (pain, dyspnea, anxiety, depression, insomnia, anorexia, nausea, psicomotricial agitation), number of visits, chase time, pharmacological actuation.
Results: N=199. Mean age: 77´6 years (50%>80 years). Man 59%. Principal caregiver: 33% spouse, 26% son/daughter, 20% nurse home, 3´5% nobody, 17´5% others. Mean previous Barthel index 71, mean Barthel index and mean Karnofsky at first visit are respectively 44´5 and 48.Patients derivation: Primary attention 44%, specialities 38%, other 18%. Derivation motive: 68% oncology, 16% geriatric, 9´5% psychiatric, 4´5% neurological, 2% other. End attention motive: stability 36´4%, die 48%, hospitalization 15´7%. Presence of symptoms: pain in 47%, dyspnea 30%, anorexia 56%, anxiety 30%, depression 33%, insomnia 35%, nausea 19%, psicomotricial agitation 20%. Mean number of visits 2´5+/-1´9. Mean chase time 45´5 days. Pharmacological actuation (new prescription): major opiate 36%, minor opiate 6%, benzodiazepine 34%, antidepressant 25%, neuroleptic drugs 40%, nutritional supplementation 33%, corticoid 14%, sedation 20%.
Conclusions:
1. There is an important functional decline in the patients and partial control of symptoms in our first visit. An earlier attention could be beneficial to the chase of the patients.
2. The big number of derivations provokes that its decrease the number of visits to the patients, so we need another HCST to maintain the same activity with appropriate quality.

PE 1.F186

The care pathway at the end of a cancer patient's life

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Introduction: In 2007, there were 1460 deaths due to cancer in the Province of Trento (450.000 residents). The amount of deaths that occurred at home was 27,5%. Only 34,9% of these patients were not admitted to a hospital during the final 60 days of their life, while 35,5% were admitted to a hospital for at least 15 days and 21,6% were hospitalized at least two times during the same period. 30% of these patients received care from palliative care services, for an average period of care of 45 days with death occurring at home in more than 80% of the cases.
Aim: One of the main objectives of palliative care is to provide care for patients in their own home therefore avoiding hospitalization: to ensure care continuity at the end of life in order to avoid inappropriate and improper circumstances. The objective of the study is to assess if and to what degree this objective was reached by investigating if care provided by palliative care services was able to influence the care pathway of the final 30 to 60 days of a patient's life by significantly modifying, or not, the need to be admitted into a hospital.
Materials and methods: The analysis of the epidemiological data, regarding cancer patients that died in 2007, compared to data regarding patients that died while receiving care by palliative care services. Assessment of a diverse incidence of hospital admittance, the length of hospital stay and the manner in which death occurred.
Discussion and conclusion: The data gathered and processed, document a significant increase in the number of cases taken into care by a palliative care service on the care pathway during the last 30 to 60 days of a cancer patient's life.

PE 1.F187

Specialised palliative care in Sweden - A needs assessment based on the Swedish palliative care directory and the Swedish cause of death register

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Aim: To describe the provision of specialised palliative care in Sweden in relation to needs as expressed by mortality statistics.
Background: The provision of specialised palliative care in Sweden, with 9 million inhabitants and a population density from 0.24 - 4 200 inhab/km2, has developed in spite of a lacking national strategy. The Swedish cause of death register provides statistical information of mortality. A majority of dying patients have some needs of specialised palliative care during the last year of life.
Methods: Based on the directory in 2008 the number of available beds in spec palliative care in each county was calculated. Also, based on the Swedish cause of death register, 2005, the total number of adult deaths and the total number of adult cancer deaths were calculated for comparisons between counties and number of available palliative care beds.
Results: The total number of palliative care services in Sweden were 152 (in-patient 82, home care 72). The number of beds were 744 and 2 612, respectively. The total number of specialised palliative care beds varied between the 21 different counties from 0 - 1 088 (total 3 356). The range of beds per 1 000 deaths was 0-76, for the whole country 37. The number of beds in relation to the number of cancer deaths followed a similar pattern.
Discussion: Specialised palliative care lack an agreed on definition which is a limitation to the directory which may be over estimating the existing number of beds. The provided information of unacceptable inequity of palliative care resources puts pressure on authorities to deliver a national palliative care strategy.

PE 1.F188

Chronic renal insufficiency in palliative care: Possible impact on drug excretion

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Aim: Impairment of kidney function has a major impact on the efficacy of renal drug excretion. However, little is known about the prevalence of impaired kidney function in patients receiving palliative care. The aim of this retrospective study is to investigate the prevalence of impaired renal function in patients admitted to a palliative care unit over an observation period of 21 months.
Methods: Data of 330 in-patients at their first admission to our palliative care unit in the defined time period, all suffering from advanced cancer, will be evaluated. Renal function is monitored by use of the glomerular filtration rate (GFR), estimated by the Modification of Diet in Renal Disease (MDRD) formula. Additionally, serum creatinine, sex, age, tumour type, and time interval from last chemotherapy are documented and evaluated.
Results: A GFR < 80 ml/min/1.73 m2 was defined as impaired renal function. Results from 229 patients (109 male, mean age 67 ± 11; 120 female, mean age 65 ± 13) show 127 of the analysed patients (55.5%) with impaired renal function, 68 of them with a GFR < 50 ml/min/1.73 m2. There is no statistically significant difference (chi-square test) in the prevalence of impaired kidney function between female (72, 60.0%) and male (55, 50.5%) patients.
Further analysis of the data is still ongoing and will consider tumour type, sex, age and the time interval from last chemotherapy.
Conclusion: Results of this study demonstrate that impairment of kidney function is frequent in cancer patients receiving palliative care. Final results will include data from 330 patients and will be presented at the congress.

PE 1.F189

Prevalence of anaemia in cancer patients receiving palliative care

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Aim: Anaemia is a common condition in patients suffering from advanced cancer and might contribute to other symptoms e.g. fatigue. Therefore, anaemia has negative effects on the patients' quality of life. The prevalence of anaemia in palliative care populations has not been well investigated yet. The aim of this retrospective study is to explore the prevalence of anaemia in a palliative care unit over a period of 21 month.
Methods: Data of 330 patients with advanced cancer, at the time of their first admission to a palliative care unit within the defined period, are being evaluated. Sex, age, tumour type, time interval from last chemotherapy and the red blood cell count parameters haemoglobin (Hb), mean cellular volume (MCV) and mean cellular haemoglobin concentration (MCH) are documented and investigated.
Results: Results of 229 patients (109 male, mean age 67 ± 11; 120 female mean age 65 ± 13) showed 166 (72,5%) of the patients analysed with anaemia of some type of severity. 16 patients showed severe (Hb<8 g/dl), 72 moderate (Hb 8-10 g/dl) and 78 mild (Hb 10-12 g/dl) anaemia. There was no statistically significant difference in the prevalence of anaemia between female (91 with anaemia, 75,8%) and male (75 with anaemia, 68,8%) patients.
Further analyses of the data is still ongoing and will consider causes of anaemia and correlations between frequency and severity of anaemia, and time interval from last anti-tumour therapy, tumour type, sex and age of the patients.
Conclusion: The findings of this study demonstrate that anaemia is a very frequent issue in patients with advanced cancer receiving palliative care. Final results will include data of 330 patients and will be presented at the congress.

PE 1.F190

The Japan HOspice and Palliative care Evaluation study (J-HOPE study): Views about legalization of death with dignity and euthanasia among the bereaved - Those who have experienced the death of a family member at a palliative care unit

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Aim: To demonstrate attitudes of the bereaved whose family members died at palliative care units towards the legalization of death with dignity and euthanasia.
Methods: This is part of large nationwide study, the J-HOPE (Japan HOspice and Palliative care Evaluation) study. A questionnaire was mailed to 661 bereaved and 429 valid answers were collected (response rate 65%). The questionnaire consisted of two parts: the first included general questions to acquire background information and the second was about the attitudes towards two end-of-life options, death with dignity and euthanasia. The respondents were asked to choose one from the following choices:
(1) the options should be legitimated,
(2) the options should be assigned to the discretion of attending physicians and
(3) the options should be prohibited.
Results: 223 bereaved (52%) approved the legitimacy of death with dignity and 160 (37%) chose to delegate the decision to attending physicians. Only 12 respondents (3%) were against the legitimacy of death with dignity. The younger (< 60 year-old) bereaved, excluding the patients' spouses, supported the legitimacy of death with dignity significantly. The proportion of attitudes towards euthanasia was similar. 192 bereaved (45%) approved the legitimacy of euthanasia, 161 (38%) chose to delegate the decision of euthanasia to attending physicians and 26 (6%) disagreed with the legitimacy of euthanasia. The respondent characteristics, which affected the choices significantly, were age and relationship with the patients.
Conclusion: Most of the bereaved supported death

with dignity and euthanasia as possible options for end-of-life moment. However, care must be taken to interpret these results because the views on the two distinct options were so similar, which might suggest some confusion over the terms.

PE 1.F191

Islamic views on death and dying

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Muslims: Worldwide every sixth person is a Muslim, are a culturally diverse group, regionally dispersed and posses various degrees of religious beliefs.
Islamic views: The Islamic Sharia (law) rules are:
Obligatory - the five pillars: confession, prayers, fasting, almsgiving and pilgrimage;
Recommended - blood and organ donation, circumcision and human tissue bank;
Permitted - DNR order, withdrawal and withheld therapy, autopsy, reconstructive surgery, contraception and reproductive technology;
Discouraged - forced feeding, smoking and divorce; &
Forbidden - abortion, surrogacy, surgical contraception, sperm and ova donation, fetal sex determination, human cloning, alcohol and pork meat.
Islam and palliative care: The palliative team should be responsive to religion when providing care, to ensure trust and ongoing patient cooperation. The dying patients are expected to seek God's help with patience and prayers. The Imam (Cleric) plays a vital role and provides spiritual guidance during illness; prepares the body for burial; and encourages the grieving family to be calm because "the dead is tortured by the crying of the living."
The Muslim patient understands that illness and suffering are part of life and death is part of a journey to meet God, "every soul shall taste death." Death is predetermined by God; therefore suicide and active euthanasia are condemned. Treatment is not obligatory when there is no hope of survival (passive euthanasia). When brain death occurs, switching off the life support is permissible, but the patient should be provided with food, drink, and pain relief until death.
Conclusions: Islam is the second largest religion, fast growing with a worldwide distribution and there is a marked increase of the prevalence of cancer in this community. Awareness, sensitivity and respect of the Muslim patient's values and beliefs are vital for effective, end-of-life, spiritual care.

PE 1.F192

Palliative care research in developing countries: Ethical deliberations and practical solutions

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Background: There is a growing need for palliative care research in developing countries to evaluate initiatives and identify areas for expansion of services. However it is acknowledged that undertaking palliative care research is not without both practical and ethical dilemmas due to the vulnerable population involved. Within the western world there are formally established research ethics processes that act to provide quality mechanisms and to protect participants. In developing countries there are limited formal systems in place, coupled with low literacy rates that may prevent truly independent informed consent and could potentially result in exploitation. It is widely accepted that the key principles inherent in undertaking research in developing countries include the duty to alleviate suffering, to show respect for people and to avoid exploitation of the vulnerable. Although the Nuffield Council on Bioethics provides guidance regarding clinical research that clearly highlights issues for consideration, in particular surrounding gaining informed consent, there is limited guidance available for palliative care researchers on the practical implementation of key ethical principles.
The aim of this paper is to discuss how palliative care researchers can transfer good practice surrounding ethical principals to developing countries. Practical issues surrounding recruitment, obtaining informed consent, the use of interpreters, payment for participants and the role of the researcher once the project is completed will be discussed. Examples from palliative care research undertaken in sub-Saharan Africa will be given to illustrate examples of good ethical practice.

PE 1.F193

Presence of advance directives in cancer patient with metastatic spinal cord compression

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Aims: Advance directives (or living wills) serve to communicate the wishes of individuals in the event that they should no longer be capable of making those wishes known. This can include directives on issues such as resuscitation status and withdrawal or withholding of care. The goal of this study is to determine at a catastrophic event such as metastatic spinal cord compression, whether advance directive is present in patient´s medical record.
Methods: Research was conducted through retrospective review of 93 charts of cancer patients with metastatic spinal cord compression who required physical medicine and rehabilitation consult, which indirectly indicate function decline from baseline. The study was performed in a tertiary cancer center.
Result: The mean age of this patient population is 54 (range 14-81) year old. Thirty three percent of patients are female. Our results show that among all patients with metastatic spinal cord compression and required physical medicine and rehabilitation consult, only 24% had identified medical power of attorney, only 19% had living will, and only 4% had "Do Not Resuscitate" request.
Conclusion: Even with strong evidences showing the median life span of MSCC patients is 5 months, it seems many patients are not aware of the urgency to have an advance directive. Further research is needed to sort out the reasons for the lack of advance directives; which could be due to lack of clearly informing patient of their prognosis from physician, or due to patients' denial.

PE 1.F194

The attitudes of Indian palliative-care nurses and physicians toward voluntary euthanasia

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Aims: In Western countries several studies have been conducted surveying the attitudes of palliative care physicians and nurses toward voluntary euthanasia. In India no such study has been conducted. We wanted to explore the attitudes of Indian palliative care physicians and nurses toward voluntary euthanasia. We also wanted to know how these physicians and nurses substantiate their point of view regarding this issue.
Methods: We opted for an explorative research design based on 27 semi-structured face-to-face interviews following Grounded-Theory methodology (Glaser & Strauss). 14 physicians and 13 nurses were interviewed from May to September 2008. At the time of the interview all respondents were working in different palliative care programmes in New Delhi (palliative-care ward, home care, hospice, pain clinic).
Results: No nurses were found to support voluntary euthanasia. Five (out of 14) physicians argued in favour of voluntary euthanasia. Putting an end to suffering and saving scarce resources were arguments mentioned each by three physicians to defend voluntary euthanasia. The main arguments against voluntary euthanasia were the fact that voluntary euthanasia is illegal in India (10 respondents), the conviction that human life is given and therefore humans should not take life (11 respondents), and a strong belief in the effect of good palliative care (13 respondents).
Conclusions: The majority of the respondents do not support voluntary euthanasia. The general opinion is that euthanasia requests disappear as soon as symptoms are treated adequately, and that pain can be effectively controlled in (nearly) all cases. Those who do support voluntary euthanasia argue euthanasia is only permissible after offering good palliative care. Among nurses the lack of support to euthanasia may be explained by their greater acceptance of the idea that life has been given to man, and should not be taken by humans.
Funds: Faculty of Theology (KUL) & VLIR-UOS

PE 1.F195

Terms and concepts used by ill and healthy people in interviews on advance directives

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Background: It has been widely discussed that it can be difficult to extract a patient's true wishes for end-of-life care (EoLC) from his advance directive (AD.) A current study in 20 healthy (H), 20 chronically ill (CI) and 20 people that receive palliative care (PCP) explores what people really want to express, using a mixed method approach. This section of the study aims to analyse the role of terms that are frequently used in interviews about people's own AD.
Methods: A focus group of experts in palliative care identified the most important semantic topics in the literature and public debate on AD and compiled key terms. Frequency analysis of these terms was conducted in transcribed interviews, including related term variations.
Results: Fourteen interviews (6 H, 7 CI, 1 PCP; mean age 64.2 (55-70) y; 5 males) with a mean length of 24:46 (16:18-32:50) min were analysed.
Semantic fields identified in the focus group were fear, suffering, trust, will/autonomy, technical device, dignity, pain. Whereas fear (hits: 0 in H, 3 in CI, 7 in PCP), suffering (6 in H, 4 in CI, 0 in PCP), trust (7 in H, 6 in CI, 0 in PCP) and dignity (10 in H, 9 in CI, 1 in PCP) play a minor role, technical device (11 in H, 24 in CI, 11 in PCP), pain (12 in H, 24 in CI, 2 in PCP) are used more frequently. Trust was mostly used when describing a proxy, pain in the context of pain free dying and most important wish for EoLC. Technical devices were not specified (terms used: machine, apparatus). Most interestingly, there was only one hit for terms in the field of will/autonomy in ill people (18 in H, 1 in CI, 0 in PCP).
Conclusions: It seems that a frequency analysis can be used to identify differences between healthy and chronically ill people with regard to their concepts of EoLC. First results suggest that terms in the semantic field of autonomy may have a different importance. Results with inclusion of more interviews will be presented.
Funded by German Research Foundation, no. NA 780/1-1.

PE 1.F196

On being disproved in decisions of life and death

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Decisions on offering/discontinuing treatment for cancer patients are usually the result of team discussions. After taking individually a firm standing for discontinuation, patients may nevertheless occasionally receive therapy contrary to ones intention and present with a meaningful outcome. Five cases are discussed and the underlying ethical issues are presented.
1) A 58year old lady suffered blast crisis of CML complicated by aspergillosis in induction chemotherapy in 1997. In a heated discussion unrelated BMT was finally decided to be offered, which the patient survived in good condition (still in fairly good health in 2008).
2) A lady of 60 years with OMF with Lille-score of 2 was advised against SCT due to the inherent risks. However she chose to move to another centre, is alive and well 2 years after SCT.
3) A 57-year old male with multiple myeloma had sepsis, pseudomembranous colitis and MOF, when all involved ICU experts voted for discontinuation. Being still alive on a ventilator after 24h without vasopressors, full ICU-therapy was resumed and survived for >4 years.
4/5) Two young patients with far advanced colorectal cancer were referred to the PCU with limited performances status for bowel obstruction or insufficient pain control respectively. In both cases cetuximab based chemotherapy could be reinstituted and led to a partial response and good quality of life for several months.
When one of these cases 3) was presented on a meeting in the intention to explain oncologists' hesitation to

discontinue treatment, a participating palliative care physician meant to invalidate the argument by the phrase "But honestly, how frequently does this happen?". The validity of this argument is challenged by reflecting upon the differences in the everyday-experience of palliative care for physicians and oncologists. Another relevant question may be "how frequently may I err in such a question and withhold a relevant gain from a patient in good intention?"

PE 1.F198

The importance of social support in decision making regarding terminal care: What ALS patients in Japan can teach us

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In this paper we shall first point to a common assumption among physicians, lawyers, and ethicists with regard to the QOL (quality of life) of severely disabled people: namely, a severe disability itself renders a person's QOL very low. This assumption was especially made clear in the recent legal controversy of Mr. Leslie Burke [R (Burke) v. GMC (2005) 3 FCR 169]. We shall demonstrate how the assumption colored the judges' opinions in the court, newspaper articles about the case, and the published opinions of various interest groups on the case. The same assumption is also often seen in the way medical ethicists refer to the case when writing on the issue of decision making regarding the terminal care.
In order to counter this assumption we shall describe the lives of ALS patients in Japan. While many of these patients have severe disabilities (i.e., they have barely movable body hooked up to a respirator), it does not seem that they necessarily feel their QOL is low. Rather, when there are sufficient social services and technical support to assist their daily activities, many ALS patients show their ability to adapt themselves to their physical disability and begin to enjoy their lives. We shall argue that it is mainly from the healthy and able person's point of view that the life in an immovable body would look poor and misery. Physical disability does not itself render a person's QOL low. The QOL felt by the people with severe disability is strongly dependent on the quality and quantity of the social support services.

PE 1.F199

Palliative sedation in palliative care unit - Own experience

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Introduction: Palliative sedation is accepted as treatment method in case of unbearable suffering (pain, dyspnea, psychological distress), which cannot be controlled by other methods. The method become more and more popular.
The goal: Evaluation of application of palliative sedation in our Department (OD) in 1995 - 2008.
Material and methods: The retrospective analysis of the cases of palliative sedation (frequency, indications, patient's consent, technique).
Results: Sedation was used only in 4 cases. Common indication was an unbearable pain, uncontrolled with other methods. In one case (mesothelioma) coexisted dyspnoea.
In two cases the "entry" into sedation state occurred unintentionally (escalation of pain treatment - infusion of analgesics). In these cases, after successful stabilization the patient was woken up to gain their opinion and an consent for continuation.
Drugs used for sedation: morphine, ketamine, midazolam, propofol.
In two cases, patients received total parenteral nutrition mainly due to family's request. Two patients- one after 3 and second after 5 days were excluded from sedation because the pain become controlled without keeping sedation. These patients continued palliative care and treatment in oncological departments.
2 patients died after 11 and 15 days of sedation - 2008.
Conclusion: Palliative sedation is very rarely used in OD. It is presumably caused by easy access to complex oncological and palliative treatment with relatively effective symptom control. The medical staff also is being reluctant to this treatment. However, we value palliative sedation as acceptable from ethical point of view. This is also not a form of euthanasia. We do not use this method for psychological and spiritual distress.

PE 1.F200

The setting of advance directives in Germany: The patients' views

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Background: It has been widely discussed how difficult it can be to extract a patient's true wishes for end-of-life care (EoLC) from his advance directive (AD). There is no evidence to which extent ADs are suited to deliver unambiguous information about a person's wishes for EoLC. This study, through a mixed method analysis of the instrument AD, aims to identify key problems that are relevant for the public, judicial and practical discourse.
Methods:
1. Semi-structured interview (INT) guideline, covering aspects such as motivation for writing an AD, wish for/rejection of interventions, personal values, proxy, diseases, prognosis, emergencies, advice/advisors.
2. Semantic and value analysis of AD in order to facilitate a comparison of AD and content of INT.
3. Triangulation. INT with 20 healthy (H), 20 chronically ill (CI) and 20 persons receiving palliative care (PCP).
Results: First results from the quantitative part of the study are presented. Seventeen INT (H 8, CI 8, PCP 1/6 male/ mean age 64.4 years (55-70 years)) with a mean length of 24:14 (15:05-32:50) min were analysed. Experience with death and dying of family members (FM) is the most frequent motivation for writing an AD (63.9%). In INT where this motivation was mentioned, talking about it took 8.8% of the total INT length (4.8% in other INT). The majority (88.2%) used prepared AD forms and did not seek any medical or legal advice (64.7%). In case of advice, it was rather given by FM (17.6%) or legal professionals (11.8%) than by physicians (5.9%). Contact persons named in AD were FM (82.4%); few gave contact details of their GP (17.6%). AD of CI and PCP contained no disease-oriented instructions.
Conclusions: First identified key problems are lack of involvement of physicians as advisors for ADs and of disease-oriented instructions in ADs. Relevance for discourse will be judged after substantiation of the results through inclusion of more interviews.
Funded by German Research Foundation, no. NA 780/1-1

PE 1.F201

Advanced directives in palliative care - A prospective representative survey in Germany

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Background: In Germany there is an ongoing debate on need and potential scope of a new law on advance directives (AD). Members of Parliament and others prepared different draft bills; a number of political actors, e.g. the German Medical Association or German Association for Palliative Medicine recommend the combination of AD with durable power of attorney for health care (DPA). The aim of the study is to assess the prevalence of AD in combination with DPA and/or appointment of legal representative for health care (AR) in different settings in palliative care.
Methods: The Hospice and Palliative Care Evaluation (HOPE) was supplemented with a checklist on ethical decision-making in two evaluation periods in 2005 and 2006 for patients (P) treated in inpatient hospices (IH) and palliative care units (PCU) in Germany. Computerised data were analysed descriptively.
Results: The ethics checklist was completed for 779 of 1903 (in 2005) and 1018 of 2846 (2006) documented P. Whereas the prevalence of all documents increased considerably in IH, it remained rather stable in PCU: AD (IH 24.5/30.7%; PCU 20.5/18.1%); DPA (IH 3.9/17.4%; PCU 16.6/13.0%) and AR (IH 6.9/12.5%; PCU 8.4/8.6%). An additional DPA was prepared for 60.9/52.2% of P with AD in PCU and 8.0/42.0% in IH; an additional AR for 22.7/26.6% of P with AD in PCU and 12.0/30.7% in IH. The correlation of AD plus DPA at the time of admission in both settings was highly significant (Cramer-V .534; p= 0.000/.587; p= 0.000). All 3 documents were given for a minority of P in both settings: 3.8% in 2005, and 4.7% in 2006. Not all P with AD were fully informed about diagnosis (2006: 93.3% in IH; 94.3% in PCU) and prognosis (2006: 80.0% in IH, 85.2% in PCU).
Conclusion: Even though there is a significant correlation of the recommended combination of documents in PC patients with an AD, the overall prevalence of AD plus DPA in PC patients is low.

PE 1.F202

A support group programme for relatives during the late palliative phase

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Introduction: This study describes an intervention where relatives were invited to take part in a support group programme during the late palliative phase of their family member. The group meets for an hour and a half a week for six weeks, and each meeting has a specialtheme with an ´expert´ invited by the pallative team. The aims of the meetings are to offer relatives a chance to meet others in a similar situation, obtain information and discuss their situation with professionals.
Aim: The aim was to describe their experiences of the support group programme and the subsequent impact on their lives as relatives of a terminally ill person.
Method: Qualitative interviews were chosen as the data collection method. The analysis was inspired by the phenomenological method as described by Giorgi (1989).
Result: The relatives´ experiences were categorised into six key constituents: confirmation; insight into the gravity of the illness; sense of belonging created by similar experiences; participation in the care system; being able to rest; and strength to provide support for the patient. These six constituents resulted in a sense of safety in relation to the patient, the illness, the nursing staff and the care unit.
Conclusion: The study´s findings show that interventions of this kind may be integral to the relatives´ ability to handle their situation when caring for a terminally ill family member.

PE 1.F203

Career satisfaction in palliative care nursing: Implications for staff retention

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Worldwide there is concern regarding the existing and projected scarcity of palliative care professionals. Without an adequate workforce patient care is seriously compromised. This international study focused on nurses and aimed to determine what contributes to career satisfaction of palliative care nurses who are registered nurses (RNs). With this knowledge workplaces can be designed to enhance career satisfaction and retention of RNs.
An interpretive research design, based on phenomenology, was used to capture a description of RNs experiences of career satisfaction. The research question was: What provides palliative care nurses with career satisfaction and what gives them impetus to continue in this field? To answer this question, nurses were asked to recall moments when they were satisfied that they had chosen the 'right' career and to write a narrative to describe this time. A web-based data-collection method was developed to solicit and receive submissions from an international sample of 89 nurses. Entries came from North America and Europe. Narrative analysis identified themes. Additional analysis used photographic and poetic interpretation. To achieve validation, continuing email dialogue with some study participants occurred. Study limitations were need for computer access and fluency in English. Ethical approval was obtained.

The major finding of this study was that RNs who perceived they provided high-quality care, made a difference for others, and made connections with their patients, were satisfied with their careers. A model for career satisfaction was developed that illustrates the possible relationship between the themes and the living out of core nursing values.
The dominant feature of this model is the cyclical nature of the positive care giving experience. Administrators, educators, and nurses need to design workplaces that facilitate this process to enhance nurse career satisfaction and retention for the benefit of patients and nurses.

PE 1.F204

Towards the optimal facilitation of family meetings in palliative care: A pilot study to evaluate clinical practice guidelines

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Despite the promotion of family meetings as an essential tool for information sharing and planning in palliative care, minimal evidence exists to demonstrate their effectiveness. We sought to rectify this gap in evidence based practice by evaluating recently developed clinical guidelines for facilitating family meetings.
Four palliative care nurses were trained to conduct family meetings using the guidelines. Family carers were required to complete a self-report instrument to measure unmet needs at three time periods: immediately before the meeting (T1); immediately after the meeting (T2); and two days after the meeting (T3). Additional data sources included phone interviews with carers and a focus group with the nurses involved in conducting the meetings. Health professionals who attended the meetings and family meeting facilitators were also invited to complete an evaluation form at T2.
Twenty family meetings were conducted at St Vincent's Hospital (Melbourne, Australia). Twenty family carers and eighteen health professionals were involved in the research. Family carers reported a statistically significant increase in having their care needs met, from T1 to T2, which was maintained at T3; they also reported that the meetings were informative, comfortable and useful. Health professionals advised that the meetings were well facilitated and family focused.
The results from this pilot study indicate that family meetings, conducted using clinical practice guidelines, were useful and effective in meeting care needs of family carers. Strategies for implementation and further research are outlined.

PE 1.F205

Family meetings in palliative care: Development of multidisciplinary clinical practice guidelines

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Background: Support for family carers is a core function of palliative care. Family meetings are commonly recommended as a useful way for health care professionals to convey information, discuss goals of care and plan care strategies with patients and family carers. Yet it seems there is insufficient research to demonstrate the utlility of family meetings or the best way to conduct them. This study sought to develop multidisciplinary clinical practice guidelines for conducting family meetings in the specialist palliative care setting based on available evidence and consensus based expert opinion.
Methods: The guidelines were developed via the following methods:
(1) A literature review;
(2) Conceptual framework;
(3) Refinement of the guidelines based on feedback from an expert panel and focus groups with multidisciplinary specialists from three palliative care units and three major teaching hospitals in Melbourne, Australia.
Results: The literature review revealed that no comprehensive exploration of the conduct and utility of family meetings in the specialist palliative care setting has occurred. Preliminary clinical guidelines were developed by the research team, based on relevant literature and a conceptual framework informed by: single session therapy, principles of therapeutic communication and models of coping and family consultation. A multidisciplinary expert panel refined the content of the guidelines and the applicability of the guidelines was then assessed via two focus groups of multidisciplinary palliative care specialists. The complete version of the guidelines is presented.
Conclusions: Family meetings provide an opportunity to enhance the quality of care provided to palliative care patients and their family carers. The clinical guidelines developed from this study offer a framework for preparing, conducting and evaluating family meetings. Future research and clinical implications are outlined.

PE 1.F206

A natural experiment: Evaluating new interventions to support carers in the UK

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Background: Carers have a central role in supporting patients with advanced disease throughout their illness and towards the end of life. Care giving is demanding and little is known about the types of intervention necessary to support them in their role.
Aim: Evaluation of 15 interventions designed to support carers of patients facing the end of life, delivered by Third Sector organisations, including hospices, in the UK.
Method: Help the Hospices, a UK umbrella organisation, funded 15 different interventions delivered by hospices and Third Sector organisations. An independent longitudinal evaluation used mixed methods to collect data: interviews with (n = 45) service providers, questionnaire data (n = 58) and interviews (n = 14) from carers. Analysis sought to determine the benefits, barriers and sustainability of the interventions.
Results: The interventions delivered included: education, information, therapeutic and social support groups, complementary therapies, and respite.
Evidence from the service providers revealed difficulties in establishing a temporary new service for which there was only transient funding, delays in appointing and retaining personnel, and lack of clarity in responsibility for service delivery in some cases. For carers, there was high satisfaction with services but overall low uptake.
Conclusion: This evaluation represents a 'naturally occurring experiment' which examines different types of support for carers in the real world. Lack of comparison samples makes it difficult to draw conclusions but the advantages of this opportunistic approach to evaluation are that it has high ecological validity and indicates where the challenges and barriers lie for services.

PE 1.F207

Interventions for supporting informal caregivers of patients in the terminal phase of a disease: Findings from a Cochrane systematic review

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Patients in the terminal phase of a disease may have complex care and support needs, and numerous other concerns. Whether the patient is at home or in a healthcare setting, and despite health professional input, it is often family and friends that play a central role in providing for their needs and concerns. Although such informal caregivers may derive personal rewards from caregiving, being a caregiver may involve considerable physical, psychological, economic and domestic challenges and stresses. A wide range of healthcare programmes and strategies are being developed and implemented that aim to support caregivers of patients in the terminal phase. Some of these have been evaluated; however this evidence base has not been reviewed systematically.
Aims: To review systematically the evidence on the effectiveness of supportive interventions that aim to improve psychological and physical health of informal caregivers of patients in the terminal phase of their illness.
Methods: Evidence will be included from controlled comparison studies that evaluate an intervention aimed to improve the caregivers' psychological, physical health, acceptability and knowledge. We will search eight citation databases for evidence, including Medline and the Cochrane library. Key stages of the review will be undertaken in duplicate. Meta-analysis will be considered for evidence from randomised controlled trials that is sufficiently similar.
Results: This review will be completed in early 2009. The review will identify which types of interventions have been evaluated and provide the evidence base for which intervention(s) may provide greater benefit to caregivers, which are more acceptable, how they are best delivered and which caregivers may benefit most.
Conclusions: The review results will allow us to draw a clear picture that highlights what we know about effectiveness, what may be more usefully implemented and where, and what interventions need further evaluation.

PE 1.F208

What can we learn from relatives of recently deceased persons to improve end of life care?

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Aim: Previous research has indicated that three quarters of the Belgians prefer to die at home, while in practice, this is not the case for the majority of them. Apart from the cost and the specific medical situation, the availability of adequate home care services and the supporting capacity of the family also determine the feasibility of home care at the end of life. The present research approaches the subject from the perspective of the relatives. The objectives of this study are to investigate the satisfaction with and the perceived quality of care in situations of end of life in different settings; to explore the well-being and the quality of (end of) life; to look at decision processes, concepts of empowerment and resiliency with respect to cure, care and care pathway decisions.
Methods: A retrospective qualitative study was performed. The prevailing array of ideas, opinions, preferences and problems related to end of life care pathway decisions and experiences were collected via focus groups of relatives of recently deceased adults. Participants were recruited by a call for collaboration disseminated through specific journals.
Results: Results of 10 focus groups (5 in Wallonia, 4 in Flanders and 1 in Brussels) will be presented. Relatives identified several conditions that increase the chance of a 'good' end of life.
Conclusion: Key points were information, open communication at all levels (i.e., within and between caregivers, family and patient), time management, and a crucial role of the general practitioner.
No external funding.

PE 1.F209

Artherapy with young children of patients admitted in PCU

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In our PCU, we propose an artherapy activity for the patients but also for their children. During this year, ten children undertook this activity.
Aims: This presentation will present the interest and the specificity of the artherapy with children.
Methods: The methods are 3 cases studies explaining this activity, the frame of the session, the media used, and the behaviour of participants.
This description will be done by a video-movie witch have been think to be more relevant.
Conclusion: This original kind of therapy allow children to stay near to their parent in difficult time, and it also provide them a free space to express their feelings. It s also help the careers, to deeply share emotional time with the patient.

PE 1.F210

Being a caregiver in Bulgaria

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The objectives: To find out the most frequent problems caregivers of cancer patients face in their everyday practice.
Methods: 198 caregivers from the Northwest part of Bulgaria were interviewed. The results: 98% of the caregivers are close relatives of the patients. According caregivers 81% of the cancer patients experience more than one symptom everyday or at least several times in week. Caregivers evaluate the intensity of the experienced symptoms as: no symptoms- 6%, light - 16%, moderate - 38%, severe - 22%, very severe - 10%, unbearable (excruciating) - 8%. The most experienced symptoms are: pain, fatigue, gastro-intestinal symptoms, psychological symptoms. 52% of the caregivers consider themselves as not prepared to act properly in critical situations. 78% of them prefer to look for help from the emergency units or from the specialized cancer hospital, as 53% of caregivers consider their General Practitioners as not prepared to take care for terminally ill patients. 36% of the interviewed declare that GPs use different pretexts to deflect their demands for palliative help as: 64% of GPs do not consider themselves trained enough to look after palliative patients and in the rural regions (36%) GPs often are not at reach when needed. All of the interviewed support the establishment of hot phone line for palliative care phone consulting. 94% of the caregivers would like home care palliative teams to help them in everyday care. 78% of the caregivers would like to have additional information I palliative care.
Conclusions: There is constantly increasing demand for quality palliative care together with the increasing survival of the cancer patients. More information, education and training in palliative medicine for the GPs and caregivers as well as development of home care teams are necessary in order to ensure qualitative and available palliative care.

PE 1.F211

Carer burdon: The impact of caring for dying patients with cancer at home

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Background: It is estimated that the majority of adults (if diagnosed with a terminal illness) would prefer to die at home. Although UK government initiatives such as the introduction of the End of Life Care Programme promote patients' choice to die at home despite this there remain a persistent number of patients with cancer who had chosen to die at home being admitted to hospital in the last days and hours of life.
Aim: The aim of this study was to explore the factors that influence this outcome.
Methodology: A qualitative study using two focus group interviews with community nurses (district nurses and community specialist palliative care nurses) was undertaken across two primary care trusts in the north west of England. Data was analysed using a thematic analysis approach.
Results and discussion: All respondents highlighted the ability of carers to cope as a major factor affecting whether patients with cancer were enabled to die at home. Influencing factors such as the ability of the family to cope and the duration of the illness are also reported. This paper discusses the results and explores potential reasons for the findings. Recommendations for the development of a carer assessment tool with appropriate supportive interventions are made.

PE 1.F212

Factors affecting agreement between patients and their family caregivers on cancer symptom experiences

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An emphasis on home care for patients with advanced disease has meant greater reliance on family members to take on the role of caregiver. Assuming this role can be challenging, particularly with regard to symptom management, where meeting the on-going needs of patients is often complex. Crucial to symptom management is the ability of the caregiver to accurately interpret and monitor the patient's symptoms since inaccurate recognition can hinder effective management, resulting in patient suffering, caregiver distress, and sometimes institutional admission. Thus, understanding factors affecting symptom assessment are imperative in supporting caregivers and developing interventions to improve this aspect of care. The purposes of the study were to: (1) examine concordance between patients and caregivers on patient symptoms and symptom distress, and (2) identify psychosocial factors that affect levels of agreement. Sixty-six patients with advanced cancer receiving home palliative care, and their primary family caregivers assessed patient symptoms using the Memorial Symptom Assessment Scale (MSAS). Levels of agreement for individual symptoms ranged from poor to excellent (ICC 0.07-0.75). Analysis of the group means using paired t-tests, revealed significant differences for the MSAS subscales (psychological, physical and general distress index), and for four of the 12 physical symptoms and five of the six psychological symptoms. The magnitude of the observed differences indicated a small to moderate bias for caregivers to overestimate, which was more marked for psychological than for physical symptoms. The results indicated that patient-caregiver dyads, in which caregivers reported greater mood disturbance and perceived burden, and patients expressed a greater sense of being a burden to others, were more disparate in their ratings. The findings add to a growing body of literature that has identified factors affecting caregivers' symptom assessments.

PE 1.F213

Examining family satisfaction with medical intensive care

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Aim: Evaluate family member satisfaction with the medical intensive care unit (MICU) experience.
Methods: Using a prospective, descriptive design and convenience sample, a survey was mailed to the designated spokesperson of patients who died in MICU or were discharged alive. Family member characteristics, admitting diagnosis, cause of death, and family satisfaction related to care, respect, physical resources, communication and decision making were collected by multiple choice and Likert-type questions. To assess differences between factors by patient status at discharge, Wilcoxon rank sum test, Kruskal-Wallis test, Dunn's procedure or Spearman rank correlations were used, depending on the levels of survey responses.
Results: 53 spokespersons completed surveys, mean age 59.0 (SD, 11.8) years. Mean patient age 60.7(15.0), mean MICU length of stay (LOS), 9.8 (9.5) days and 34 patients (68.2%) discharged alive. Mean overall MICU satisfaction by spokespersons was very good (range, poor-excellent) and was higher in male responders (P=0.04) and responders of patients with respiratory failure (P<0.01) and long LOS (P=0.01). MICU satisfaction was associated with perception of teamwork (r = .722), courtesy shown (r = .713) and having opportunity to spend time at the bedside (r = .697; all P<0.001). Of themes, satisfaction was highest in caring practices and communication (very good-excellent) and lower in physical resources and decision making (good-very good); results were higher for caring practices and communication in patients with long MICU LOS and sepsis, hypotension or respiratory failure diagnoses compared to short LOS and other diagnoses (all P< 0.01), but not by spokesperson characteristics.
Conclusion: Spokesperson satisfaction was high, even when death was the outcome, but varied by patient factors, caregiver behaviors, and environment. It is important to assess satisfaction and make changes to improve the experience for families.

PE 1.F214

Developing a tool for measuring main caregiver´s fears

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Background: Palliative Care Teams have shown interest in evaluating effectiveness in interventions by "resolution of doubt sessions. The aim of these sessions is to decrease main caregivers´fears. The first step to do this, is to develop a validated tool for measuring fears.
Aims: To validate a questionnaire to identify the main fears of the primary caregivers.
Method: Creation of a nominal group composed by professionals in Extremadura PCTs for the development of the questionnaire. Selecting a group of national experts whom were sent the questionnaire independently developed by the group rated for qualitative assessment (yes / no) and quantitative (0minor-10major score) of each one of the questions according to their relevance, accuracy, clarity and understanding. It was made a section for comments. An analysis of the median scores for the selection of items and suggestions for changing the registration of some of the statements was made. The new questionnaire modified was sent to experts for their assessment on where they come expressed: the initial questions of validity of registration; ammendements by the reviewers, and the questions changed in response to comments described. The agreement between all the suggestions to accept changes should be made to respond with a Yes / No. Now, the reliability of the instrument is being checked in a pilot study to 125 caregivers of terminally ill patients. Uniformity and consistency of questions and items will be verified by statistical analysis to measure the Cronbach alpha coefficient.
Results: The nominal group designed a questionnaire comprising 60 questions divided into 6 sections. We selected a total of 23 national experts, 16 (70%) participated in the assessment of the survey. The survey finally was reduced to 25 questions spread over 6 sections.
Conclusion: The cohesion of the teams, experience in working together, and the consensus of a panel of experts have created a poll fears in the primary caregiver.

PE 1.F215

Conspiracy of silence prevalence in terminal cancer patients in Extremadura

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Introduction: Within the palliative care regional program in Extremadura a study has been created with the aim of knowing the conspiracy of silence prevalence, factors associated to conspiracy presence and evolution during the disease final stage. The results of conspiracy of silence are launched.
Method: The study was conceived in 3 stages:
(1) Prevalence prospective descriptive study,
(2) analytical study of associated factors,
(3) follow-up study on the evolution of patients presenting conspiracy of silence. Sample: cancer patients being followed-up by palliative care teams (PCT). Older than 18 years.
Variables:
Patient characterization.
Disease diagnosis.
Date of death.
Presence of conspiracy of silence at the inclusion time.
Associated factors: knowledge of the disease process, instructions comprehension level, economic level, main carer relationship, adequate home existence, age and sex.
The data were collected and analyzed (frequency distribution) in the regional palliative care observatory

of Extremadura.
Results: The data were collected on 21/04/08, 09/06/08 and 15/09/08.
All the PCT take part on the study (N=8).
422 patients were included, 309 (73.2%) were studied (X= 71 years, 61.8% male). In 204 patients (66.02%) conspiracy of silence was detected.
113 patients (26.8%) were excluded by these reasons: they were included previously and/or they present a high limitation in comprehension and/or absence of main carer.
The prevalence data are represented by area.
Conclusions: The conspiracy of silence prevalence in patients assisted by PCT in Extemadura is 66.02%. Posterior analysis will allow identifying the factors associated to conspiracy of silence and their evolution during the disease course.

PE 1.F216

Caring for a person in advanced illness and suffering from breathlessness at home: Threats and resources

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Background: Little is known about the factors that mediate the caregiving experience of informal carers at home, which could inform about ways of supporting them in their caregiving role.
Aim: To investigate the caring experience of carers for patients with an advanced progressive illness (COPD, heart failure, cancer, MND), who suffer from breathlessness.
Methods: A purposive sample of 15 carers was selected. They were recruited via the patients they cared for (who suffered from COPD, cancer, MND, heart failure), from the hospital, and the community. Data were collected through semi-structured, in-depth interviews. All were tape-recorded and transcribed verbatim. The analysis used a Grounded Theory approach and NVivo software facilitated the management and analysis of the data.
Results: Several key issues affected caring in a positive or a negative way. The threats to caring were uncertainty, carers' own health problems, an imploded world, negative reactions from outside, person-loss and acute exacerbations. Resources that carers drew on were acceptance, self-care, availability of support, feeling that caring is a shared responsibility with the patient, and 'getting on with' caring in case of emergencies. Breathlessness was particularly challenging and carers did not have any strategies to relieve the symptom. They were ill prepared for acute exacerbations.
Conclusion: Carers need to be included into opportunities for support provision in advanced illness. Negotiated involvement of a health professional could buffer the heavy responsibilities related to home care. They could provide problem-solving skills, and build on the resources that carers draw on in response to what they experience as most threatening to their caring role.

PE 1.F217

"I can see it in her face when her breathings really bad": Living with breathlessness: The experiences of caregivers

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Background: Family members are increasingly relied upon to provide care & support in the management & monitoring of patients' symptoms at home. Breathlessness is a common, distressing symptom in patients with advanced disease however it is unclear how carers' experience patients' breathlessness, and how this affects their day-to-day life.
Aim: To explore informal carers' experiences of patients' breathlessness & understand its effect on their daily lives.
Methods: In-depth qualitative interviews were conducted with carers as part of a larger study on the experiences of breathlessness across different settings & conditions. Secondary qualitative analysis of this dataset was performed. Transcripts were coded using NVIVO & analysed using the Framework approach.
Results: 12 caregivers were included (11 spousal & one daughter). Carers described breathlessness in dramatic, visual ways and emphasized the work of breathing by using frightening & vivid language. They described a 'vigilant' role, keeping watch for signs of patient breathlessness. Carers felt that breathlessness limited patients physically, causing anger & frustration. They also described a sense of loss of previously shared activities and future plans. Breathlessness itself led to carer anxiety & fear. Although breathlessness impacted negatively on carer quality of life, the process of caring was associated with some positive benefits & comforts as well as burdens. Carers expressed a need for more information on managing the situation & future expectations.
Discussion: Caregivers perceived breathlessness to be a frightening symptom affecting both patients and themselves. It impacted on caregivers' lives by limiting shared activities, changing the nature of personal relationships & causing carer anxiety. Health professionals need to involve carers in education about the management of patient breathlessness and recognize their anxieties.

PE 1.F218

Costs and determinants of home-based palliative care in Canada

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Restructuring health care in Canada has resulted in an increasing emphasis on the provision of ambulatory and home-based palliative care. Acquiring economic evidence is critical given this trend and its tremendous demands on family caregivers. The purposes of this study were to:
1) comprehensively assess the societal costs of home-based palliative care; and
2) examine the sociodemographic and clinical factors that account for variation in costs over the course of the palliative trajectory.
Four hundred and eight family caregivers were recruited from three palliative care programs in two Canadian provinces. Participants were interviewed by telephone every two weeks from time of palliative care referral until death; the mean data collection period was six months. Family caregivers were asked to report health care appointments, diagnostic tests, travel expenses, time devoted to providing care, and lost time from the labour market. Demographic, social, and clinical characteristics were also measured. The mean monthly cost of care per care recipient was $18,981 (2006 CDN); public expenditures accounted for 22% of this cost. The majority of total costs were comprised of family caregivers' time costs. Multivariable linear regression indicated that care recipients with low levels of physical functioning had higher total costs than those with higher levels of functioning (p=0.02) and care recipients who had longer episodes of care, had lower monthly costs (p=0.02).
Information regarding how costs vary across individuals may aid policy makers and mangers in deciding how to allocate resources to particular care recipients. Greater clarity regarding the cost implications associated with an episode of care may both improve access to palliative care by shifting further the emphasis to such services. It is hoped that the findings will assist in the formulation of health planning and resource allocation initiatives.
Funded by the Canadian Institutes for Health Research.

PE 1.F219

Differences in health care professionals' satisfaction when caring for neurological versus oncological patients - A pilot study on a palliative care unit

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Background: Around 20% of patients in our palliative care unit suffer from neurodegenerative disorders (ND). In team discussions, several team members reported more difficulties and less satisfaction when caring for ND patients as compared with cancer patients.
Methods: An interdisciplinary focus group developed a questionnaire aimed at evaluating professional satisfaction with the care of ND and cancer patients by the various professional groups of the palliative care team, as well as possible factors contributing to the perceived difference, using numeric rating scales (0-10).
Results: The return rate was 90% (n=26; nurses 94%, doctors 83%, psychosocial/spiritual workers 86%). A significantly lower satisfaction in caring for ND vs. cancer patients was reported only by the nurses´ group (5.9±1.8 vs. 7.7±1.8, p=0.03), but not in the other groups. Similarly, the perceived success of caregiving activities was rated significantly lower for ND patients only by the nurses' group (5.2±1.8 vs. 7.7±0.9, p=0.001). Factors strongly contributing to this reduced satisfaction (scoring ≥7 on a 0-10 scale) from the nurses´ viewpoint were: increased amount of time required for care (8.6±1.4), impaired verbal (8.3±1.9) and non-verbal communication (7.1±2.3), higher demands from the patients (7.3±2.0), difficult behavior of the relatives (7.1±2.8), and difficulties in dealing with relatives (7.0±2.1). Physicians only regarded the impaired verbal (8.3±1.6) and non verbal communication (7.9±1.2) as aggravating circumstances, while the psychosocial/spiritual team members found no particularly aggravating circumstances.
Conclusions: Palliative Care nurses on our unit report significantly reduced satisfaction when caring for ND vs. cancer patients, mainly due to higher workload, communication barriers and "difficult relatives". A larger study is in progress to validate these findings and to suggest improvement strategies.

PE 1.F220

Complemetary and Alternative Medicine (CAM) in palliative care patients

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Objective: The use of complimentary and alternative methods is common in oncology, but nothing is known about the role of CAM in the last days of patient's life.
Material and methods: Between 1-2007 and 10-2008 the palliative care team treated 85 patients (50 male, 35 female, median age 62 years) on out-door base. All families were asked to complete a structured questionnaire regarding the use of CAM during the last period of patient's life. Patients suffered from cancer in 83/85 patients (98%), two patients had neurologic disorders.
Results: Only 20 families (31%) have not used any CAM. Spiritual support (praying, hospice services) was asked by 60/85 families (71%). 25/85 families (29%) reported about drug use. Favourite methods were vitamins (n=11, 13%), trace elements (n=9, 11%), and mistletoe (n=8, 9%). 30 patients (35%) were treated by physiotherapy (28 oncology patients, 2 neurology patients). Logopedy and ergotherapy were used in 10 patients (12%). 12 families (14%) reported about aroma-therapy in patient's care. Main information source was the GP (house physician) (45/85, 53%)), followed by the palliative care team (30/85, 35%) and pharmacies (27/85, 32%). Internet, journals or self-service information were used by 25/85 families (29%) only. The effectivity of the categorized methods was estimated between 1 and 5 (very good - worthy) by the patients or their families. Following ranking was registered: spiritual support 2.4; physical therapy 2.7, logopedy/ergotherapy 3.1, drugs 3.3. 65/85 families (76%) were satisfied with the information received from the health care practitioners.
Conclusion: Complementary methods are often practised during the last days of a patient. Families and friends are looking for valid information and need help by the professionals. The different methods have to been evaluated regarding effectivity as well as acceptance by the patients.

PE 1.F221

Breast cancer in a family and the community at large

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The diagnosis of breast cancer has a devastating impact on the patient and the family; the disease is increasing in alarming manner leaving many families in poverty and young ones without parents.
Purpose: To explore the difficulties a family undergoes while taking care of a cancer patient.
A survey done at Ruiri village, Meru District has shown that in every six [6] families there are two patients with breast cancer undergoing treatment or newly diagnosed. The immediate families are more depressed and suffer along way with the patient, hence reducing their performance at work.
There is increasingly poverty in the family forcing them to sale their properties in order to afford the treatment, more affected are the young mothers whose children

depends on. Having a patient means stopping most of daily activities especially when a patient becomes paraplegic, 3 out of 5 patients ends up being paralyzed increasing dependence to others and half of the patients partners ends up remarrying hence stopping the support. The illness mostly spread to the bones especially of the spinal cord [back] complicating the support, treatment and increasing finances problems. Many families got problems in accessing strong painkillers making their life a night mere, It has shown that most of the patients needs wheelchairs which our health intuitions not able to supply to all patients hence becoming a challenge to the family members. Buying is another issue since by the time patient is paralyzed the family has spent all the savi.
There is need to increase palliative/hospice care to village level and availability to strong painkillers in affordable prices. Health care providers need to understand the patient's background first in order to be able to assist the patients and also the community be aware of the hospice services being offered.

PE 1.F222

An experience of Buddhism based palliative care 1: How nurses see the role of Bonze at Vihara unit?

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Introduction: Spiritual and/or religious component must be one of the most important aspects in Palliative care. However, modern, conventional Wards in Japan are not regarded as a working place for priests. Therefore although nearly two hundred PCUs are operating nowadays, not all the units employ a full-time priest. In addition, among 190 PCUs, there are only three units which clearly state that they founded by Buddhism.
Association of Buddhist Vihara was formed about 15years ago as a voluntary organization of Bonze who willing to help one of the PCU based on Vihara concept. Through their activity, we try to examine the function of Bonze at PCUs in Japan.
Objective: As the first Step of our investigation, We ask how their colleagues, i.e. nurses see their function in the ward in order to understand the role of priest in Buddhism based Palliative Care Unit.
Method: Semi- structured private interview was performed by two sociologists at the ward. All conversation was recorded and convert into transcript. Atlas.ti was used for some part of text analysis.
Result: 8 nurses were interviewed. 4 of them were recruit with in a year.
The longer they work with bonze the vaguer they realize what to expect them to play.
Discussion: In order to obtain a full time post as a professional in a hospital organization, clear job description is required. Less experienced Nurses have more clear vision about Bonze. What does it mean? Their job style may not fit for the concept of the profession? More examination is needed.

PE 1.F223

Palliative care model and Romanian health care system

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Palliative care brings a new philosophy, the individualised whole person care. Population might be so much accustomed with the existing health model and pleased that no changes are desired.
Aim: To explore populations experiences of health services when caring for PC patients and expectations towards health services.
Method: Face to face survey of a representative sample of the general population drawn from electoral list administered by a national survey company in September 2008.
Results: 1250 people were surveyed. 225(18,1%) had the experience of caring for a patient with advanced or terminal disease. This patients received episodic care at home 66,8%, in a state hospital 52.1%. The patients were treated in hospitals competently always 20,7%, usually 32,1%, if money was offered 26,2%, with respect always 19.4%, usually 35.1%, if money was offered 26%, sufficient help for personal care was offered always 18.5%, usually 29,8%, if money was offered 30,7%, never 3%. When the whole sample was asked to rate the care received in a hospital in a serious disease they said it was competently always 11,3%, usually 17,7%, if money was offered 46,6%, with respect always 11,2%, usually 16,7%, if money was offered 46,4% sufficient help for personal care always 9,6% , usually 14,2%, if money was offered 47,6%, never 6%. All respondents when confronted with medical care for a serious illness rated as very important and important investigations and blood test 97%, complete medical exam 92,2%, time for communication 91,8%, privacy 87,3%, emotional support 81,2%, respect for values and spiritual life 78%, involvement in decision 65,9%.
Conclusion: Elements of the PC model detailed examination, emotional and spiritual support are important for the population. This major focus towards investigation might put pressure on palliative care services for unwanted procedures and raises questions what is rated as competent care. Further indept interviews needed. EU funded grant.

PE 1.F224

Cross-country differences in physicians' beliefs about end of life care: The USA and Hungary

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Aim: This study aims to assess, compare and contrast knowledge and perceptions of primary care physicians in the United States and Hungary regarding end-of-life care and hospice. We hypothesize that differences exist due to the duration and breadth of hospice availability in each country.
Methods: Purposive samples of physicians from Hungary and the U.S. were obtained and surveyed. A voluntary, self-administered survey and cover letter were mailed to all practicing family physicians (339) in Baranya County, Hungary. The survey was written in English, translated into Hungarian, and pre-tested on Hungarian faculty physicians. After similar vetting in the U.S., the survey and cover letter were mailed to 300 family practitioners and general internists in Summit County, Ohio in the U.S. Descriptive and bivariate analyses were conducted using SPSS.
Results: The response rates were 54% in Hungary (n=182) and 48% in the United States (n=145). Seventy-two percent of U.S. and 0.5% of Hungarian physicians reported that currently available services for the terminally ill were exceptionally good. Fifty-eight percent of U.S. physicians indicated they were quite knowledgeable of hospice compared to 10% of Hungarian physicians. Five percent of U.S. and 38% of Hungarian physicians believed that discussing a terminal prognosis with the patient leads to hopelessness. Some similarities existed in beliefs about the appropriateness of interdisciplinary care teams and palliative care for terminally ill patients.
Conclusion: Results illustrate differences and similarities in physicians' beliefs about the care of terminally ill patients between the two countries. Divergent responses may be viewed as a snapshot of each country's evolving approach to end-of-life care. Such a picture, though fixed in time may help physicians, educators, and administrators to plan for the future in both educational and clinical arenas. The U.S. Fulbright Program and the Summa Foundation funded this study.

PE 1.F225

Cancer reflected in the non-medical written press

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Main beneficiaries of palliative care services are cancer patients. Cancer is a disease that caries a special significance transmitted throughout the whole care of the patient. Media is newly a "educating realm".
Aim: To find out the meaning associated with cancer in the non-medical press.
Method: The database of the main national newspapers was searched using the words: cancer, leukaemia, mieloma, patient doctor communication cancer for the period April 2003-April 2008. A qualitative and quantitative analyses was produced.
Results: 1334 articles were retrieved, 884 were included in the analyses after excluding those article using cancer in pejorative sense (usually incurable disease of the society, politics etc). The number of articles has increased steadily in the researched period (93, 94, 158, 268, 271) without any special monthly pattern or correlation with medical events. Qualitative analyses revealed 10 major themes: cancer-pain-death associations (395), education for health (368), personalities (197), incompetent health care system (162), humanitarian help (93),achievements in the health system (69), life stories (66), international progresses in cancer (54), faith (25), alternative treatments (15).
Conclusion: The cancer-pain death association is reflecting the medical reality of late diagnoses of cancer associated with reduced survival. Progressive increase in number of article on health education (risk factors, protective factors, awareness campaigns) shows the maturity of the press and involvement in education for healthy life style. The predominant negative image of the health system in the media is maintaining the mistrust and favouring late presentation to medical check. there was an unexpected low number of articles referring to alternative treatments.

PE 1.F226

The process of recognising dying - Anything but a simple diagnosis

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Aim: With the introduction of care pathways for end-of-life care, recognising dying as a key process for a pathway-decision is of increasing interest. This paper aims to show that recognising dying goes beyond a simple clinical diagnosis and is influenced by a number of factors.
Methods: As part of an ongoing research project on recognising and acknowledging dying in home care, a critical literature review was done. It covered a broad range of literature, including clinical aspects and state of the art diagnosis in medical literature, as well as research evidence and social theory on transition into the dying phase. The literature search included databases such as PubMed and CINAHL, Web of Science, palliative care textbooks and library catalogues.
Results: There are three main areas of theoretical discourse which influence recognizing dying, specifically clinical and professional issues, organizational issues and social issues. With regard to clinical issues, palliative medicine provides the context for the most elaborate debate of how dying can be "diagnosed". However, results also underline a number of difficulties in the practice of diagnosing dying with issues of institutional background among them: Rules, routines and communication within organisations play a major role, and key elements are also contained in issues of hierarchy and professions as well as the institutions' conceptual orientations (e.g. hospice versus hospital). Recognizing - and even more so, acknowledging - dying, finally, is a social process in which the dynamics of a number of people, first and foremost the patient and his or her family, must be taken in account.
Conclusion: To know more about the interplay between these issues may help to overcome well documented barriers of recognizing dying in literature. In light of this, it is essential to overcome a solely body-related orientation, and therefore an interdisciplinary approach in research and practice is essential.

PE 1.F227

Palliative care non cancer

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Background: Palliative medicine aims to provide a professional response to patients and families suffering advanced organic diseases.
Aim: To describe the experience regarding patients and families of professionals treating patients with

advanced organic diseases.
Method: Open answer interviews to medical teams treating patients with heart failure (HF), chronic obstructive lung disease (COLD), liver disease (LD), chronic kidney disease (CKD) and geriatrics. The questions about patients included symptoms, worries, difficulties for decision making, and experiences during the process. Questions related to families included care environment and frequent needs. Questions to the medical team included information-communication issues, ethical dilemmas, education needs, and sanitary resources needs for giving an adequate follow-up.
Results: The different organic diseases shared some symptoms such as: dyspnea (HF, COLD and CKD), osseous and muscular pain (HF and geriatrics), and delirium (LD, CKD and in geriatrics). One common concern was the loss of autonomy. Most caregivers expressed burnout and feelings of impotence. The medical team needs were more sanitary education, continued follow-up by the reference team, and availability of a palliative care team.
Conclusions: Patients with different advanced organic diseases share some common symptoms. Consensus and integration in their care could be helpful since experts in palliative care are needed among the specialists' teams, and specialists are needed in palliative care teams. More scientific evidence is needed in order to identify prognosis factors in the final phase of these conditions.

PE 1.F228

Amyotrophyc lateral sclerosis: From first symptom to the last breath

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Background: Amyotrophic lateral sclerosis (ALS) is a terminal neurodegenerative disorder affecting motor neurons which aetiology still is unknown. It is characterised by the preservation of cognitive, sensitive and autonomic nervous system functioning.
Aim of study: To chronologically describe the main clinical, psychological and social issues related to this disease.
Method: One case report (from the initial diagnosis to death) based on open response interviews and review of clinical records.
Results: Male patient, aged 46 years old, divorced, one son, and suffering from hypothyroidism. In May 2006 he was diagnosed with ALS. During the first year of the disease, main symptoms were weakness and walking impairment. After being diagnosed, he was emotionally impacted and reported feelings of fear and anxiety. He was also worried about the future of his son and his own. During follow-up, the patient experienced dysphagia and respiratory difficulties. The occurrence of these symptoms generated a more active participation of the multidisciplinary team for making consensus decisions with the patient. In the emotional sphere, fragility, fear of future and anxiety increased. In the social sphere, because of his high functional dependence the patient decided to live in an old people's home. The patient died in April 2008 at the Palliative Care Unit with his family and his usual medical team.
Conclusions: ALS is a devastating disorder involving social, physical and emotional components. In order to attend patient and family needs it is necessary to make a global assessment and to have a multidisciplinary team (psychologist, neurologist, logopedia expert, and lung diseases physician). Also, a home medical team would be helpful.

PE 1.F229

Symptomatic therapy of dyspnea in patients with advanced chronic heart failure

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In times of reduced mortality from myocardial infarction and ageing of the population, numbers of patients suffering from chronic heart failure continues to rise. In spite of optimal cardiological treatment, many patients will still suffer from dyspnea. The use of opioids for the relief of breathlessness in cancer patients is common, because of well known barriers there exists few experience in patients with chronic heart failure. We conducted a limited systematic literature research in order to find out if there is evidence for the use of any systemic pharmacologic substance for the symptomatic relief of dyspnea in chronic heart failure patients. First, electronic searching of the literature in the following databases was done: CINAHL, EMBASE, MEDLINE and PUBMED (until 2008 week 33). The reference lists of relevant articles and reviews were hand searched. Every type of study was included.
Ten relevant articles were found, seven were excluded. There was no substance group found apart from opioids. No relevant chart reviews, case reports or other low-level evidence papers could be identified Three papers were randomized, double blind controlled trials with an evidence level Ib. One study revealed an effect of five mg oral morphine on dyspnea over the whole day. Two studies found a positive effect of oral dihydrocodeine (1mg/kg) and 1 or 2 mg of intravenous diamorphine during a single exercise regarding dyspnea and exercise capacity. The number of patients in all studies ranged from ten to sixteen.
The quality of the identified studies allows the use of opioids in patients with chronic heart failure with clear limitation due to the small numbers of patients.
Further studies are strongly recommended to lower the barriers for the use of opioids in non-cancer patients for the symptomatic treatment of dyspnea and improve the quality of life of this growing population.

PE 1.F230

Attitudes towards death of patients feeling severely affected by Multiple Sclerosis in Germany

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Aims: Aim of this project was to assess how German patients severely affected by Multiple Sclerosis (MS) address death in the context of their disease.
Methods: Episodic interviews were conducted with 15 patients feeling severely affected by MS. The interview guide concentrated on perceived needs, feeling severely affected and the understanding of the concept of "palliative care". Questions about death were not raised explicitly.
Interviews were recorded, transcribed verbatim and analysed by qualitative content analysis in regard to the thematic field of death.
Results: The sample included 6 men and 9 women living in various areas, age range 24-73. From 15 interviewed patients, 11 unasked entered the thematic field of death. Their approach can be divided into 4 strategies to deal with this topic:
1) trivializing,
2) bearing,
3) soothing and
4) abstracting.
These correspond to 4 different attitudes to death:
1) death is not relevant,
2) take up the duty to live,
3) desire for death and
4) need to speak about the end of life.
Of the 4 interviews where the interviewees did not enter the thematic field of death, 2 were enjoying their lives. They managed to accept help from others and concentrated on what abilities and possibilities in life they still have. Another patient hoped that his condition will improve and he can return to his earlier life style.
Conclusion: Death in the context of MS is an important topic for patients feeling severely affected as they brought up this topic spontaneously. The different perspectives on death might require various approaches to patients. Palliative care can offer interventions which correspond to their strategies, e.g. support in coping with fear and with one´s fate, offering alternatives in crises and help in getting contact with inner feelings. How these interventions can be applied concretely to these MS patients should be a matter of further investigations.
The study was funded by Gemeinnützige Hertie-Stiftung.

PE 1.F231

Attitudes of severely affected Multiple Sclerosis patients and their health professionals towards palliative care

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Aims: Aim of the project was to elaborate how palliative care (PC) is understood by patients feeling severely affected by Multiple Sclerosis (MS) and by health professionals caring for them.
Methods: Episodic interviews were conducted with 15 patients feeling severely affected by MS. Focus groups and expert interviews were held with 23 health professionals. The interview guide covered questions about feeling severely affected, perceived needs and the understanding of the concept of PC.
Interviews and focus groups were recorded, transcribed verbatim and analysed by qualitative content analysis. Here results of the analysis regarding the understanding of PC are presented.
Results: MS patients hardly knew the term "PC". They had heard about it mostly in context with dying and death and therefore they did not regard it as a possible approach for themselves. Hospices were known as institutions for cancer patients in which their wishes and the concerns of relatives are the most decisive factors. A more detailed explanation of the concept of PC, however, aroused interest in patients.
For health professionals PC was predominantly associated with dying cancer patients and death. As according to the interviewed physicians neurological patients would not die of their neurological disease, PC was not regarded as necessary for them. Nevertheless they stated that they offer enough palliative care for their MS patients.
Conclusion: All stakeholders show a lack of accurate knowledge of PC and associate it with death. This leads to fear, discomfort and rejection of PC on patients' and health professionals' side. Therefore PC has to communicate its approaches widely, especially that PC addresses all patients with an incurable, progressive, life-limiting diseases i.e. also to patients suffering from neurological disease like MS. PC does not want to substitute neurological care for MS patients but to complement it.
The study was funded by Gemeinnützige Hertie-Stiftung.

PE 1.F232

Developing palliative medicine services for dementia

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Aim: Dementia currently affects approximately 700 000 people in the UK, with cases predicted to rise to 1.7 million by 2051. In common with other progressive life threatening conditions, it has been recognised that the principles of palliative care may apply to patients with dementia. The reality, however, is that most patients who access hospice and specialist palliative care in the UK have cancer. A recent document published by the National Council for Palliative Care highlighted the importance of creative partnerships in developing palliative and end of life services for people with dementia and the need to formalise successful local practice.
Method: A steering group was initially formed with a view to developing better palliative medicine services for people with dementia in the North Tyneside area. In order to educate and encourage debate surrounding the issues in providing palliative care for people with dementia, a one day conference was held in July 2007. The delegates at the conference were all asked to highlight the areas of maximum importance for future development. These topics were then discussed further in a workshop of local providers of care for those dementia held in January 2008. These responses were collated to develop a working document to inform service provision and as a resource for further research and debate.
Results: The four highest rated topics were: Advanced care planning, Psychological support, Managing acute events and Terminal care. The results of the workshop has been summarised in the diagram below.
Conclusions: The final report from this consultation process is currently being written with the areas for future service development clearly outlined from the discussions that have been held. The goal of improving the quality of care for those with dementia must not only be highlighted and debated at a national level, local services and service providers must be involved in order to ensure that these goals can be met.

PE 1.F233

Quality of dying at a cardio-thoracic tertiary referral centre - A survey

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While the disease trajectory for cancer is predictable with a well-defined terminal phase, the course for organ failure remains unpredictable. Often characterised by a series of exacerbations and remissions, progressive deterioration can culminate in gradual or sudden unexpected death, leaving patients without any discussion of end-of-life care preferences or closure. We analysed all the deaths in our hospital in 2007 prior to the introduction of a Supportive Care Pathway.
Aim: The main aims were to document the current practice and to identify patients who were known to palliative care as a marker for good death.
Method: The list of all deaths in 2007 was obtained from the hospital. Case studies were randomly selected from a list of patients who had stayed > 7days for in-depth analysis to identify possible triggers for timely referral to palliative care.
Results: In 2007 there were 8266 admissions and 129-recorded deaths. Age range 22-96 over half between 65-96. Of the 129 patients in the study, 7 were diagnosed with neoplasm, 9 with heart failure, 20 with valvular heart disease, 4 with cardiogenic shock, 3 with fatal arrhythmia, 7 with cardiomyopathy, 52 with myocardial infarction/ atherosclerotic disease, 9 with pneumonia/respiratory disease, and 18 others (i.e. aortic dissection/endocarditis).
Half the patients (64/129) were in hospital for over a week before they died. A third of patients (21/64) were known to Palliative Care. Data from the in-depth analysis suggests that timely involvement of Palliative Care results in better outcome.
Conclusion: This retrospective analysis of the quality of death in a cardiothoracic tertiary referral centre, illustrates a wider role for joint Palliative Care support alongside active treatment in patients with end-organ failure. Furthermore, data from in-depth case studies have identified a number of potential triggers for timely referral to Palliative Care, aimed at improving the overall outcome.

PE 1.F234

What do relatives think are important aspects of care in patients with severe stroke?

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Stroke is the third commonest cause of death in the United Kingdom. Little research has been done into the care of these patients. This study aimed to explore the needs of patients who were either dying from stroke or had a poor prognosis after a stroke.
Qualitative in-depth semi-structured interviews were carried out with relatives of patients who had had severe strokes, admitted to an acute general hospital. Interviews were conducted at least seven days after the acute event but while the patient was still in hospital. Severe stroke was defined as a patient who had a National Institute of Health Stroke Scale (NIHSS) score >15 and poor prognosis in the judgement of the multi-disciplinary stroke team. The interview schedule covered all aspects of care: physical, psychological, social and spiritual. Questions were also asked about information giving by health care professionals and involvement of patients and family in decision making and place of care.
Ten relatives were interviewed. At this point no new topics emerged and saturation was achieved. The patients ages ranged from 28 years to 94 years (mean 74 years), four were female and six male. Their NIHSS scores ranged from 15-21 (mean 18). First degree relatives were interviewed in eight patients, an unrelated but named next of kin in the remaining two. Basic comfort care and treating the patient as an individual was thought to be central to good care. How information is given to patients and their relatives, especially when prognosis is uncertain, was also considered by relatives to be extremely important. Many relatives expressed difficulties with the current care provided in all the above areas and some gave practical solutions of how these may be tackled.
This research begins to tackle the lack of research into end of life care in stroke patients. It's findings will contribute to the design and improvement of end of life care services for patients dying of stroke.

PE 1.F235

Symptoms in non-cancer conditions near the end of life: Identification and comparison of the most common symptoms in advanced chronic kidney disease and advanced chronic obstructive pulmonary disease

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Aim: To describe and compare symptoms towards the end of life in patients with stage 5 chronic kidney disease (CKD) and stage III and IV chronic obstructive pulmonary disease (COPD).
Methods: Secondary analysis of data from prospective longitudinal symptom surveys in two non-cancer populations -
1) patients with stage 5 CKD managed without dialysis, and
2) breathless patients with stage III and IV COPD.
Baseline data was extracted and analysed in SPSS for two validated ordinal scales, the Memorial Symptom Assessment Scale Short Form (MSAS-SF, measuring symptoms) and the Palliative Performance Scale (PPS, measuring functional status).
Results: Data was extracted for 133 respondents, n=73 with stage 5 CKD and n=60 with stage III and IV COPD. Although CKD patients were significantly older (mean age = 80.8 yrs vs 65.2 yrs in COPD, $p < 0.01$) the groups had similar functional status (mean PPS = 62.1 in CKD and 61.5 in COPD). Symptom burden was high in both populations, with a mean of 12 self-reported symptoms from MSAS-SF in CKD and 14 in COPD. Shortness of breath (78%), lack of energy (75%) and drowsiness (63%) were among the five most frequently reported symptoms in both conditions, but other common symptoms were disease-specific: 79% of CKD patients had itch and 58% had swollen legs, while 78% of COPD patients had dry mouth and 53% had cough. Some symptoms were disproportionately more severe in each condition, notably itching and pain in CKD, and shortness of breath and dry mouth in COPD.
Conclusion: Symptom control needs are high for patients with advanced CKD and advanced COPD, but while some symptoms (such as shortness of breath and lack of energy) are common to both groups, others (such as itch or cough) are disease-specific. Understanding these patterns of similarity and difference informs the adaptation of 'standard' palliative care services, which have been developed largely for advanced cancer patients, for those with non-cancer conditions.

PE 1.F236

National Hospice Organization (NHO) terminability criteria for the heart failure. Are valids in our hospital?

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Introduction: We have terminability diagnostic criteria for non oncology patients. The NHO criteria for heart failure are:
1) Dyspnea classes III-IV according to the New York Heart Association Functional Classification.
2) Echocardiography with ejection fraction less than 30%.
3) Ideal treatment with ACE inhibitors/Angiotensin II receptor antagonist, vasodilators and diuretics.
Objective: To describe the usefulness and validity of the NHO terminability criteria for the heart failure in our internal medicine service. We are taking as a reference those patients who died during their admission period with this disease.
Patients and methods: It is a descriptive study in which we gathered all patients who died in the internal medicine service of the University Hospital "Puerta del Mar" during one year. These patients suffered from heart failure in their diagnosis. We carefully observe if these NHO criteria are correctly used and achieved. We use Word and Excel informatics applications to study the results.
Results: From 58 patients, we notice that:
- Dyspnea classes were described in 31%. Of these cases, 84% dyspnea classes are III-IV types.
- Ejection Fraction was described in 31%. Of these cases, 30% shows an ejection fraction lower than 30%.
- The medical treatment when the patient was admitted in hospital was: ACE inhibitors/ Angiotensin II receptor antagonist: 33%. Diuretics: 43%. Vasodilators: 19%.Three drugs: 8%.
Conclusions: With the limitations of our study (number of patients, only died patients, descriptive types....), the information obtained suggests:
1) Dyspnea class is described in a very low percentage of our sign. But when it occurs, there is a correlation with a dyspnea class III-IV.
2) As the same way it happens with ejection fraction (that is, it is very low), but in this case, when we measure the ejection fraction, there is few patients with ejection fraction less than 30% (only the 30% of them).
3) The treatment of these patients were not correctly done.

PE 1.F237

Prognosis markers in patients who presented heart failure and died in our medicine internal service

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Introduction: Actually, there is a growing interest to know prognosis markers to predict the mortality of our patients, especially patients with chronic and progressive non oncology diseases. In this way, we will be able to apply the suitable measures for diagnosis and treatment in agreement to their clinical situation. The more important chronics and progressive non oncology disease is the heart failure due to its high prevalence, economic expense and high morbimortality.
Objective: To present possible prognosis markers in patients with heart failure at the moment of the admission in the hospital. We are taking as a reference those patients who died during their admission period with this disease.
Patients and methods: It is a descriptive study in which we gathered all patients who died in the internal medicine service of the University Hospital "Puerta del Mar" during one year. These patients were diagnosed with heart failure. We describe clinical and analytic variables that could arise as prognosis markers due to its high percentage of appearance in our patients studied and died. We use Word and Excel informatics programs to study the results.
Results: We find the following results.
From 58 patients studied, we observe these factors:
- Comorbilitys associated: 93%
- Anemia (haemoglobin <10 mg/dl): 79%
- Hyponatremia (<135 mg/dl): 20%
- Renal dysfunction (Creatinine >1.3 mg/dl): 40%
- Altered mental status: 31%
- Hyperglycemia (>120 mg/dl): 65%.
Conclusions: With the limitations of our study (number of patients, only died patients, descriptive cases ...), the results obtained suggest that there are markers which can work as bad prognosis markers in the moment of the admission in hospital in those patients who suffered from heart failure. In our study, we highlight:
- Comorbilitys associated
- Anemia
- Hyperglycemia
- Renal dysfunction.

PE 1.F238

Palliative care for Indigenous renal clients living in remote Australian settings. A new model and public health collaboration

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The incidence of end-stage renal disease (ESRD) in the Northern Territory of Australia is significantly worse than most parts of the world with its Indigenous population developing ESRD at rates 30 times above the non-indigenous Australian population. The burgeoning numbers of indigenous ESRD patients has severely stressed existing strategic & clinical responses to service delivery which has focused upon institutional haemodialysis within regional centres rather than remote community based options where the majority of indigenous population live in which has brought about significant social dislocation and undermined community coherence. Palliative care services have had to cope with the concomitant escalation of patients dying of ESRD. Territory Palliative Care has traditionally had to cope with very late referrals in hospitalised patients at the point of cessation or non initiation of haemodialysis. The dislocation from community has meant that the capacity to make the journey back home, in preparation for their death, as a culture imperative, often fails through lack of time, available transport options and poorly reorganised

community & family supports. A long-term public health integrated collaboration between the Northern Territory's Renal Services, Preventable and Chronic Disease Programs and Territory Palliative Care is implementing significant changes in the model of care within communities in the care pathways and decision making processes for ESRD management that engage patients and communities earlier, initiate advanced care planing and present palliative care options. In respecting patient and family decision making and cultural practices it is hoped that the changes will make a meaningful difference to the lives of patients, their families and communities as a whole. This presentation will detail the elements of the collaboration and the model between services and present the preliminary data and evaluation of the changes and their impact.

PE 1.F239

Symptom prevalence and assessment of palliative care needs in people affected by advanced and progressive neurological conditions (Parkinson's disease and related disorders of Progressive Supranuclear Palsy, Multiple Systems Atrophy)

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Background: Few people affected by Parkinson's disease (PD), and related movement disorders - Progressive Supranuclear Palsy (PSP), Multiple Systems Atrophy (MSA) have access to palliative care, yet conventional medical treatment (e.g., with dopaminergic drugs or surgery) is usually ineffective (MSA, PSP) or associated with severe unwanted effects in the late stages of the disease (PD). In recent years, specialist palliative care services have increasingly recognised the needs of non-cancer patients.
Aims: This study sought to assess physical symptom prevalence and wider concerns (psychological, social, practical and information needs) of patients with progressive neurological conditions.
Methods: We collected data on symptoms and problems of patients as self-reported to interviewers in their homes on standardised questionnaires (Palliative Care Outcome Scale (POS) and POS-S symptom checklist).
Results: 50 patients were included, mean age 68 yrs; 31 had PD, 11 PSP, eight MSA; 40/50 had severe disability/unable to walk independently. Patients reported a mean of 11 physical symptoms. Six symptoms affected more than 80% of patients: problems using legs, using arms, fatigue, pain, dribbling and feeling sleepy. Whilst six further symptoms: difficulty communicating, swallowing, stiffness, falls, bowel and urinary problems were reported in over 50 %. Four symptoms occurred in less that 25%: nausea, vomiting, poor appetite and pressure sores. The concern of this population extends beyond these physical symptoms. Over 50% had anxiety and depression. 50% had information concerns. 25% said they did not have anyone to share how they were feeling. The mean POS score was moderate, approaching 14 out of a maximum of 40.
Conclusion: At least 12 physical symptoms are highly prevalent, which need appropriate symptom control. Many symptoms and concerns in people severely affected by PD and related disorders are as prevalent as those experienced by patients with advanced cancer.

PE 1.F240

Improving the quality of end of life care for patients with heart failure: An audit of specialist palliative care involvement with heart failure patients

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Aim: To audit the involvement of a hospital specialist palliative care team with heart failure patient.
Methods: Retrospective case note audit against criteria set out in the UK National Service Framewor for Coronary Artery Disease:
(1) Number and percentage of people with heart failure referred
(2) Access to palliative care
(3) Good symptom control and psychological support should be offered.
Results:
(1) 18 patients had been referred (2005-2007), all in New York Heart Association Class III and IV. The number of referrals is low given the prevalence of heart failure.
(2) The specialist palliative care team had accepted all referrals. 15 patients (83%) were seen the same day, two patients were seen within 24 hours and 1 patient within 48 hours.
(3) Patients were referred for symptom management (13), support (4) and discharge planning (4).
All had multiple symptoms: 11 patients (61%) had 3 or more symptoms. The most frequently reported symptoms were breathlessness (89%), anxiety (72%), pain (44%) and nausea/vomiting (28%). Typical interventions were opiates and benzodiazepines for breathlessness, opiates for pain and appropriate anti-emetics for nausea. Taking into account confounding factors, there was evidence that interventions benefitted for breathlessness (56%), pain (75%), anxiety (54%) and nausea/vomiting (80%). 56% of patients' relatives had required significant support.
Conclusion: Given the prevalence of heart failure the referral rate is low. To enhance collaborative working between palliative care and heart failure services the team have maintained their open referral policy and also attend the heart failure multidisciplinary meetings to further develop links made between the services. This audit will be repeated after 12 months to reappraise how these links between the two services have developed.

PE 1.F241

Perceived needs of German patients feeling severely affected by Multiple Sclerosis: Results of a survey

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Aims: In order to improve the care of patients feeling severely affected by Multiple Sclerosis (MS) it is necessary to assess their perspective on their perceived needs.
Methods: A questionnaire was developed in a three step procedure including consultations of experts and cognitive interviews with patients. The questionnaire consisted of closed questions about socio-demographic and disease specific characteristics as well as of four open question about feeling affected, wishes for more support, perceived help and problems.
The questionnaire was mailed to all members of the German MS society in April 2007 in the society´s journal "aktiv!". Of the 1110 questionnaires returned between April and July 2007 a 40% probability sample (N=444) was chosen for analysis. A framework of categories was inductively developed in an iterative process in order to analyse answers to open questions.
Results: Reasons for feeling severely affected by MS were impairment in mobility (65%), confrontation with losses and changes (50%) and feeling weak (32%). The subjective estimation of being severely affected correlated with the EDSS at 0.536 (Spearman-Rho, p<=0,01).
Respondents experienced a sense of relief by emotional support (69%), quietness or distraction (51%) as well as cotherapies (38%). Medical care provision was mentioned only by 23%.
As so far unmet needs were mentioned: better financing of services (43%), better social integration (32%), better medical treatments (30%) and more help in everyday life (28%).
Conclusion: Results show that care for severely affected MS-patients should not only concentrate on physical aspects. The consequences in everyday life, social network and personal identity have to be addressed as well. We hypothesize that the palliative care perspective with its multi-professional approach might help in meeting these multifold needs.

PE 1.F242

Incorporation of end of life care into heart failure treatment

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Background: The number of patients diagnosed with heart failure (HF) is increasing. Improvement in treatment has enabled longer survival following initial diagnosis. HF patients are confronted with frequent hospitalizations, increasingly debilitating symptoms, and the ever present risk of dying, as 14% of incident cases die within 6 months. Until recently, the primary focus has been on curative care. Quality of life (QOL) and palliative care (PC) seems to have been relatively neglected.
Aims: To evaluate to what extent palliative care interventions are incorporated into HF care; to what extent the existing PC knowledge base is applicable to cardiology PC; and what are the PC issues specific to cardiac patients.
Methods: A literature review was conducted. Key data bases were systematically searched for studies on HF combined with symptoms, mortality, cause & place of death, end of life/PC and advanced HF.
Results: Cardiac patients are confronted with many of the same symptoms at end of life as cancer patients. However, the causes, mechanisms and treatments differ to a certain extent. Specific challenges include identification of a "dying phase", disengaging implanted defibrillators, avoiding unnecessary treatments and procedures, and caring for patients on waiting lists for heart transplantation. Few centres offer end of life care for HF patients. Those HF programs that do have access to palliative professionals have shown positive results.
Conclusions: HF care specialists have little or no training in palliative/end of life care. PC specialists have little training in the specifics of cardiology PC. A model of total care for HF should include networks of HF and PC specialists working with primary care and home care nurses. By incorporating PC consultation into specialist HF programmes, total care for patients with HF and their families could be maximized. Challenging cases should be treated jointly with PC specialists to optimize end of life care.

PE 1.F243

The palliative care needs of people living with HIV in Kenya and Uganda: A multicentre qualitative study

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Aims: The majority of care for the 20 million Africans with HIV is provided through non-palliative settings. To scale-up generalist palliative provision from diagnosis to advanced disease, the specific needs of patients and families need to be determined. This study aimed to identify domains of need in order to generate specific clinical recommendations.
Design and methods: A qualitative study among patients, families and staff in a sample of 12 HIV care facilities in Kenya and Uganda. A semi-structured topic guide was administered, transcripts were forward/back translated, interviews transcribed verbatim and imported into NVIVO for analysis, and a coding frame generated independently in the UK, Kenya and Uganda before a unified agreed code applied to the entire dataset. The dataset was coded between the international research team. At an interim and final point in the coding process, coding was reviewed to ensure that each node was internally consistent.
Results: 192 interviews were conducted. Conceptually, identifying care recipients and providers was complicated by the interaction between an individual being a patient, carer, advocate and staff member. Patients described a number of principally clinical and social unmet needs. A number of manageable symptoms were identified, including pain, itchy rash and diarrhoea. Social problems centred mainly on poverty and the lack of food. Patients were responsible for large family units, bringing further disease-related poverty and advance care planning for orphans.
Conclusion: In order to achieve integrated palliative care in HIV care facilities, a number of steps need to be achieved. The palliative needs of patients must be recognised within HIV medicine, assessment protocols adopted, and interventions taught. Palliative "total care" needs to take account of poverty and the impact of disease on the wider family in resource-poor settings.

PE 1.F244

The development and audit of a new self-assessment questionnaire/referral tool for patients attending an interstitial lung disease clinic

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Aim: Achieving timely referral to Palliative Care services for patients with both malignant and non-malignant disease has proved problematic. We have devised a self-assessment questionnaire for patients with interstitial lung disease (ILD). This has been piloted in a weekly respiratory clinic to empower patients to report issues causing them concern, and to facilitate appropriate referrals. The outcomes of this questionnaire were audited over a 3 month period.
Methods: The support needs questionnaire was developed as a collaboration between the Supportive and Palliative Care Team (SPCT) and the ILD team in 2007, based on previous known research in this area. New patients attending clinic are given a questionnaire to complete prior to seeing the doctor. The questionnaires were audited between July and September 2007. Comparative referral rate data from 3 months before implementation was also collected.
Results: A total number of 79 questionnaires (68% response rate) were returned during the audit period. 24 (30.4%) patients received follow up: 16 by telephone, 7 seen in clinic, 1 by letter. Of these, 9 (37.5%) were identified as requiring ongoing support. Other outcomes included 1 referral to social services and 2 referrals to breathlessness clinic. Patient comments regarding what could improve quality of life included: "help with uncontrolled panic breathing", "less fatigue", "to have help in home and garden". Only 1 patient was referred from ILD clinic in the 3 months prior to questionnaire implementation.
Conclusion: Our findings suggest that there are significant unmet needs in patients with interstitial lung disease: a large proportion of patients had questions and worries that they requested assistance with. This questionnaire has assisted in enabling patients to receive timely referral to SPCT services. We have modified the questionnaire and are currently piloting it in other areas across the hospital.

PE 1.F245

Is there any evidence for palliative care in psychiatry? Results of an integrative literature review

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Aim: The origin of psychiatry itself is a result of moral and political decisions against stigmatisation and exclusion and for understanding mentally ill persons and their needs. But in spite of reforms in mental health services, sufficient evidence and phenomenon lead health care provision regarding palliative care in psychiatry is lacking. This 5-stage integrative literature review process focussed on
(1) palliative care needs in psychiatry,
(2) specific palliative care needs of mentally ill persons in psychiatry,
(3) an outline of the state-of-the-art and evidence based interventions and
(4) a comparison of these with the current practice in the field of psychiatry.
Methods: German and English literature was analysed during an alternating sensitive and sensorical research in
a) computer based databases (Ovid, Embase, CareLit, CINAHL, Medline, SOMed, PsyConnet, PsycIndex and GeroLit),
b) monograph catalogues (KVK, booklooker.de) and abstract volumes and
c) a web based research for literature.
We used keywords, such as "Palliative care" and "Psychiatry"[MeSh] for literature published between 01/1990-09/2008. In- and exclusion criteria were documented as well as a detailed research history. This strategy resulted in 34 final articles and 10 books or book chapters.
Results: The literarture review shows the topic to be a continually published theme in international literature. Publications usually deal with the role of psychiatry in palliative care, palliative care for gerontopsychiatric patients, psychiatric complications of terminal illness or psychotherapeutic interventions. But palliative structures or evidence based interventions in psychiatry are a neglected topic. Only 7 pilot shemes for palliativ care in psychiatry and 6 studies could be identified.
Conclusion: Palliative care of mentally ill people is limited to gerontopsychiatric patients. Psychiatric and mental health services lack of palliative care structures and evidence based interventions.

PE 1.F246

Challenges for HIV palliative care in Romania

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Palliative care is an essential component of HIV/AIDS clinical management from the time of diagnosis to the end of life. Romania is one of the few countries in Central and South-Eastern Europe with a significant number of people affected by HIV/AIDS, including a large group of adolescents, over 7000, who are in fact the children infected in the period 1987-1991. They are long time survivors and are faced with difficulties of social integration, access to education and jobs, stigma and discrimination, in addition to the usual issues related to medical care and treatment.
A 3 year pilot project was developed in 3 cities of Romania - multidisciplinary teams received specialist training and in close collaboration with infectious disease specialists in Brasov, Bucharest and Bacau provide integrated specialist palliative care to people living with HIV/AIDS (PLWHA) and their families, to improve their quality of life. Bereavement support is offered to families of deceased patients.
A number of challenges have been met so far, the most common being lack of knowledge and understanding about HIV infection both in the general public but also amongst healthcare professionals, not only about HIV and AIDS but also about palliative care. Stigma and discrimination are unfortunately encountered by PLWHA on a frequent basis, which makes them cautious about approaching another medical team. Hospital staff may feel threatened by the involvement of other specialists and collaboration between services can be extremely difficult. Lack of resources and poor access to specialist investigations and treatments can be frustrating for the team and those in their care.
To address some of these difficulties, the project includes educational activities for healthcare professionals from all specialties and backgrounds to improve awareness and understanding of HIV and also a campaign in schools to educate the younger population.

PE 1.F247

Metabolic factors among advanced dementia patients with pressure ulcers in respect to their sex

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Patients with advanced dementia when they are no longer able to recognize food, feed themselves independently more often suffer malnutrition and are at high risk to be bed bound. As they are bed bound they at higher risk for development of pressure ulcers.
Aim: To determine which female or male sex is more susceptible for development of metabolic complications in patients with advanced dementia and pressure ulcers.
Methods: Newly admitted, non-cancerous patients {females (F) (n=13), males (M) (n=13)}, to Home Hospice For Adults Of Association Of Volunteers Of Palliative Care In Wielkopolska with advanced dementia (Alzheimer disease, vascular, severe cognitive impairment) were mached age, pressure ulcers severity (Thorrance scale), feeding status (MNA) and erytrocyte sedymentation rate (ESR), complete blood count (CBC). Among this mached groups the clinical profile as blood pressure, waist circumference and metabolic factors as: concentration of total protein and lipids profile: total cholesterol (T-C), HDL-cholesterol (HDL-C), LDL-cholesterol (LDL-C), triglicerydes (TAG) and activity of superoxide dysmutase (SOD-1) were estimated.
Results:
1. F in comparison with M had lower waist circumference (p=0,007) (74±8 and 85±10cm), Systolic Blood Pressure (p=01) (114±21and 134±15mmHg) respectively.
2. M vs. F had lower T-C (p=0,02) (135±27 and 163±31mg/dl) and LDL-C (p=0,02) (70±25 and 95+28 mg/dl) respectively.
3. In males positive correlation for SOD-1&total protein (R=0,6, p=0,025) and negative correlation for SOD-1&Thorrance scale (R=-0,62, p=0,024) was observed.
4. No correlation in females group.
Conclusions: Pressure ulcers status can be effectively predicted by using Thorrance scale in combination with knowledge of sex, blood pressure, and lipids profile. As intracellular marker SOD-1 correlate with Thorrance scale in males it will enable nurses to communicate more effectively and evaluate the therapeutic plan of care in different sex patients.

PE 1.F248

Determinants of the anxiety in chronic renal failure patients

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Aims: The purpose of the study was to assess the intensity of anxiety of patients following renal transplantation and dialysis patients, to establish the determinants of the level of anxiety of this patients, and to find out an effective coping strategy with anxiety in chronic renal failure patients.
Methods: The study involved 84 patients, aged between 23 and 80, who were qualified to one of three study groups, according to method of treatment. The following research instruments were used: the State-Trait Anxiety Inventory), Scale of Personal Religiousness, the Mental Adjustment to Cancer Scale , the Rotterdam Symptom Checklist.
Results: The chronic renal failure patients revealed normal level of anxiety state and anxiety trait. Results of Kt/V correlated with anxiety state and psychological state assessment, and results of eGFR correlated with physical state assessment. The change of appearance, necessity of change style of life and over all quality of life influenced on level of anxiety state in group of patients after renal transplantation. Psychological state assessment correlated with anxiety state in hemodialysis patients, and pain, level of activity had an effect on anxiety state in peritoneal dialysis patients group. The coping strategies as helplessness - hopelessness, anxiety preoccupation correlated with high level of anxiety state in study groups.
Conclusions:
(a) The chronic renal failure patients don't reveal heightened level of anxiety state and anxiety trait;
(b) The women demonstrate higher level of anxiety trait than the men in study group;
(c) The method of treatment is a differentiating factor in respect of determinants of anxiety level in study subject;
(d) Results of Kt/V, change of appearance and style of life, bad quality of life, pain and low level of activity correlate with high level of anxiety;
(e) The helplessness - hopelessness and anxiety preoccupation doesn't effective coping strategies with disease.

PE 1.F250

Why and when are palliative care patients admitted to hospital?

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Aim: To see why and when palliative care patients present to hospital.
Methods: The notes of all consecutive medical patients admitted in January 2008 defined as having palliative care needs were reviewed with a standardised proforma at 2 acute hospitals in an NHS Trust.
Results: 47 patients were identified as having palliative care needs. 11 patients had been identified by primary care as 'palliative'. Around half of the 47 patients did not have cancer. Active treatment was the aim of admission in 55% and symptom control in 28%; less than 10% were referred for end of life care or because they were not coping at home. 34 patients were admitted out of hours (OOH). Of these 34 patients 11 lived alone, 11 with spouse/family, 4 were from a residential care home, 4 from a nursing home and 2 other. 12 of the 47 patients lived alone - 11 were admitted OOH. Of the 11 previously identified 'palliative' patients, 7 were admitted OOH, 3 in hours & 1 unknown. 10 had a DNAR form and 4 were placed on

the LCP. Of the 47 patients, 15 were placed on the LCP. 11 died in hospital, 1 went home, 2 went to a nursing home and 1 remained an inpatient at the end of the audit. 4 of the 15 patients had an identified place of care and 2 of them got there.
Conclusions: Most patients presenting with palliative care needs had not previously been identified as palliative and were admitted for active management of a problem. They were more likely to be admitted to hospital OOH than in hours, especially if they live alone. Most had DNARs in hospital and nearly one-third of patients were placed on the LCP. Preferred place of care was poorly documented for patients on the LCP - only 2 got to their preferred location. Communication between primary and secondary care is vital in this patient group to ensure that patients are cared for optimally in the location that is both appropriate to their needs and acceptable to the patient, and to try to prevent unnecessary out of hours admissions.

PE 1.F251

Cardiac symptom control program development

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Cardiac disease remains the top killer in Canada and heart failure is a chronic, inexorable debilitating illness with increasing prevalence in the elderly population. With the aging of the population, we expect cardiac disease to remain the top few diseases to cause significant morbidity and mortality in the Canadian population. Coupled with the other chronic illness associated with age such as dementia, renal disease etc, the care of the heart failure patients is becoming increasingly complicated and with significant symptom burden.
International heart failure guidelines include palliative and hospice management recommendations, in which a multi-disciplinary approach is the most appropriate strategy.
Symptoms are the primary driver of patients seeking urgent or emergent help and result in frequent access of the health care system, including visits to the emergency department and hospitalizations. This is despite best management practices and maximal heart failure management.
A joint program between the Departments of Cardiology and Palliative Medicine was developed to better manage the refractory cardiac symptoms for heart failure patients. This initiative has started with a pilot project call the Heart Function Clinic - Palliative Care Clinic (HFC-PCC) since 01 July 2008.
The target population is symptomatic patients, 'frequent flyers' to the Emergency Department because of refractory cardiac symptoms with near end-of-life issues. The goal is to divert these patients who are very symptomatic and whose standard cardiac management has been maximized, to the HFC-PCC.
The role of the HFC-PCC is to evaluate the patient using standard palliative care tools, stabilize symptoms and reduce symptom burden. Joint management includes nurse and physician teams nested within the HFC-PCC.
In summary, HF care is in desperate need of high-quality research and knowledge translation to improve care for this growing segment of the HF patient population.

PE 1.F252

Defining and describing continuity in supportive and palliative care: The stakeholder view

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Background: Continuity of care is a priority identified by cancer patients and is cited as an aspiration in health and social care policy and practice guidance. There is sparse evidence in the literature of a shared definition of continuity of care, nor how it is manifested in the provision of supportive and palliative care services.
Aim: This qualitative case study sought views on continuity of care from those involved in the planning, management, provision and use of palliative care services in a Primary Care Trust (PCT) in England.
Method: Semi-structured (40) and group (2) interviews were used with a purposive sample drawn from within the boundary of the PCT. Data were supplemented by analysis of relevant documentary material and observation of eight meetings. Qualitative thematic analysis was conducted using techniques from Framework and with NVivo software.
Results: Most informants described continuity of care in terms of relationships between professionals and service users, although there were differences in the degree to which individual or team approaches were specified and considered appropriate. Systems for information transfer and for overseeing care were highlighted. Service users valued consistency in the technical care and information they received. A lack of role clarity between generalists and specialists can compromise continuity and there was evidence that some viewed changes in service configuration as a threat to relational continuity in particular. No single definition of continuity of care predominated.
Discussion: Findings demonstrate that relational continuity remains important for most stakeholders but flag the potential tensions inherent in differing constructions of continuity between service users and providers. Systems for transferring information between care settings need further attention as does the way in which professionals negotiate their roles and responsibilities in relation to supportive and palliative care services.

PE 1.F253

First Croatian national research: "The need of the citizens of Croatia for the palliative care and the establishment of a hospice" as the contribution of the implementation of the palliative care/medicine in Croatian health care system

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Aim: To establish the level of informativeness of citizens about palliative care generally, and a need of the citizens of 7 croatian cities for palliative care and the establishment of a hospice in the Republic of Croatia. To estimate the citizens satisfaction with current organization of health care in their towns in providing adequate care for terminally ill patients. To establish, by evaluating health professionals´ experience, the percentage of patients who need palliative or hospice care.
Methods: The survey was conducted by two anonimous questionnaires. One for the survey of non-health professionals, total of 1564 persons, while the second questionnaire aimed to evaluate the attitudes of health professionals in 7 croatian cities, 789 subjects.
Results: The total percentage in agreement with implementation of a palliative care system in Croatian towns and counties amounts to 90.6%. A total of 88% of the citizens and health workers consider the establishing of hospices in their town or county to be necessary. The need for organizing a system of palliative care is also supported by the level of citizens´ satisfaction in the surveyed towns where 43.3% of citizens think that little attention is given to terminal patients, while 13.4% of them consider that such patients are not given any attention at all. On the other hand, 1.8% of the respondents think that plenty of attention is given to terminal patients in their towns. In addition, 35.6% of citizens are of the opinion that Croatian state hospitals take very little care of terminally ill patients. 16.3% of the respondents think that these hospitals take no care at all of terminally ill patients, while 3% of the citizens answered that Croatian state hospitals take the utmost possible care.
Conclusions: Is that the organization of palliative care and continuous education in pallitive medicine are an indispensable and urgent need and wish of the citizens, as well as the establishment of a hospice.

PE 1.F254

Amyotrophic lateral sclerosis: Multidisciplinary team

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Background: Amyotrophic lateral sclerosis (ALS) is a terminal neurodegenerative disorder affecting motor neurons which aetiology is still unknown. The disease usually course with limbs weakness, dysphagia, weight loss, and respiratory failure.
Aim: To describe the way in which a multidisciplinary team (MT) coordinates for attending patients and families biopsychosocial needs. MT work is addressed to both patient and family. The MT is made up of patient and caregivers together with: neurologist, lung physician, physical therapist, logopedia therapist, dietician, nurse, social worker, psychologist, and palliative care specialist. The main priority in the therapeutical relationship is to enhance patient's autonomy during the decision making process. Communication is a dynamic process and information to patients and families is given progressively. The MT gives continued care from the diagnosis to the end of the disease. Patients are diagnosed by a neurologist and symptoms and information are treated and delivered promptly. During the course of the disease, it is necessary to keep patient's hope and to give psychological support for both patients and families since family members play a central role in patient care.
Conclusions: The MT intervention enables detection of needs, treatment adequacy and facilitates a tailored care. The MT improves patients' quality of life during the process and adjusts patients and families expectations.

PE 1.F255

Physiotherapy in palliative care: Luxury or necessity?

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Aim: The objective of this presentation is to discuss the growing role of physiotherapy in Palliative Care and to highlight the areas in which physiotherapists can assist both patients and carers.
Results: It is widely recognized that physiotherapists assist with the physical aspects of care, namely rehabilitation/ reconditioning; and the management of symptoms, such as pain and fatigue. However, what is becoming more apparent is that physiotherapists also have an impact on the psychosocial aspects of care. This may be in assisting patients to realize a particular goal, the maintenance of ´hope´ or the management of symptoms such as breathlessness. Physiotherapists also have an educative role, and combined with their other skills, can be utilized to assist carers more confidently care for patients in their own home.
Conclusion: Despite growing evidence to support the role of physiotherapy in Palliative Care, many services have limited access to physiotherapy services. In identifying the range of ways in which physiotherapists can assist patients and carers, this presentation emphasizes that the inclusion of physiotherapy in Palliative Care services is indeed a necessity, not a luxury.

PE 1.F256

A multidisciplinary team for pain and palliative care in a university hospital

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Introduction: Since 2006 the departments of Anesthesiology, Medical Oncology and Neurology of the Erasmus Medical Center cooperate in a multidisciplinary intramural consultation team for pain and palliative care. The team supports in the management of pain and other problems in advanced cancer patients.
Method: For each consultation, the reason for asking the team for advice and daily assessments of the intensity of pain were recorded in a database. Pain intensity was measured by the Numerical Rating Scale. Since 2008 the intensities of other symptoms were measured using the Edmonton Symptom Assessment System (ESAS).
Results: The number of consultations increased from 130 in 2006, to 200 in 2007 and 118 in the first half-year of 2008. The time between clinical admission and entry to the team was less than three days for the majority of the patients. Pain was the most frequent reason for consultation (in 97.5% of the consultations in 2006, 92.1% in 2007, and 83.1% in the first half-year of 2008), but the number of consultations for other symptoms than pain increased.
In 2006 the intensity of pain at entry was > 4 for 94.2% of the patients; in 2007 this was the case for 86.8% and in the first half-year of 2008 for 78.6% of the patients. Two days after admission the percentages of patients with pain intensity scores > 4 were decreased to 42.9%, 40.1% and 43.2%, respectively. All patients also suffered

from other symptoms, as recorded by ESAS. For most patients the ESAS scores improved during the first 72 hours.
Conclusion: The number of consultations almost doubled in two years. Pain remains the primary reason to ask a consultation, but the team was increasingly consulted for other symptoms than pain. The high percentage of advanced cancer patients with pain at entry urges increased awareness of pain in the medical and nursing caregivers.

PE 1.F257

Advise from experts: Consultation in palliative care in the Netherlands

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Background: In the Netherlands a unique nationwide palliative care consultation service (PCCS) is initiated by the government in 2004. The regionally organized Comprehensive Cancercenter are responsible for the organization, assessability, facilitation, coordination and quality of this PCCS. Consultants are specially trained physicians and nurses, with a lot of experience in palliative care, working in multidisciplinary teams, 39 teams nationwide. They inform, support and advise professional caregivers in inpatient and outpatient care settings regardless of patients' diagnose.
We present data on characteristics of requesting caregivers, kind of questions en problems discussed as well as characteristics of patients involved.
Methods: Data are derived from an electronic registration database / patient file which is completed by the consultants directly after a consultation case.
Results: 6026 advises are registered in 2007, mostly about cancer patients (86%), average age 67. About 1 out of 4 patients have a prognosis shorter than a week. The questions concern a wide range of problems but mostly concern treatment of pain, nausea, dyspnea and delirium. 74.1% of the consulting professionals are general physicians. They frequently have questions about organization of care and about pharmacological issues. In a substantial amount of questions palliative sedation is an issue of discussion.
Conclusions: We believe that PCCS is a valuable service especially beneficial to general physicians at the moment. Possibilities to better address caregivers in hospitals and nursinghomes need to be explored.
In the presentation more is to be told about the organization of PCCS in the Netherlands and the way in which we ensure quality of advise.

PE 1.F258

Use of UK voluntary sector cancer support services

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Aim: Voluntary Sector Cancer Support Services (CSS) are a growing feature in the range of resources available to people affected by cancer in the UK. Previous studies have produced inconsistent findings about why clients use CSSs, and which aspects of services are important to them. This study sets out to address these issues.
Methods: This research used case study methodology focussing on one CSS which provides counselling, complementary and creative therapies to people affected by cancer (patients, families and bereaved people). Interviews to discuss influences on use of the service were conducted with 19 service clients. In follow-up interviews clients were asked about their experiences of the service and therapies. Interview transcripts were subjected to thematic analyses based on Grounded Theory principles.
Results: Preliminary findings suggest clients' reasons for coming to the CSS vary, but can be grouped into three broad areas. Some clients report wishing to use a specific therapy as a tool to solve a specific problem (a ´Toolbox´ or problem-solving approach). Others report seeking a 'Sanctuary' in which they feel calm and cared for (an emotionally based approach). A third ´Ambivalent´ group appears to be unsure about their reasons for coming to the CSS or in what ways it can help them. Follow-up interviews suggest key aspects of clients' experiences coalesced around emotionally based support; the benefits of feeling cared for, and an appreciation of the relaxing 'milieu' of the CSS.
Conclusion: Clients who initially report seeking problem-solving support from a CSS often appear to shift from this initial motivation, later reporting having valued the experience in terms of a sense of being cared for. Amongst possible interpretations for these findings is one that some clients initially find it easier to identify problem-solving needs rather than emotional needs. This may have implications for modes of access to the service.

PE 1.F259

Careprogram palliative care in the Netherlands: Networkcare improved!

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In the Netherlands the last few years 72 networks palliative care have been established. The organisations, professionals and volunteers who work together in these networks are looking for a model to make an overview of palliative care on operational level in there region. Aim of this model is to make palliative care in the region more transparent and make it possible to improve the quality of palliative care.
The Association of Comprehensive Cancer Centres (CCC´s) in the Netherlands have started an innovative learning project together with 9 networks. Based on national standards and patients problems a model is developed which helps caregivers to make the providing of treatment and care in the region transparent. The concept of the model has been reviewed during 7 months by caregivers in the 9 participating networks.
The model is a practical tool to make the providing of care more transparent. The model makes gaps and overlap in treatment and care more visible within networkregions. These gaps and overlap are an incentive to develop projects for improvement and innovation of treatment and care in the region. The model encourages better cooperation between the various organisations and caregivers. After evaluation of the review period the model has been adjusted. The model and corresponding instruments are a basis for development of an internet application, which is a condition for nationwide implementation.
There is a lot of enthousiasm for working with the model. A plan for implementation of the model in the other networks in the Netherlans has been developed. To make this possible in this project support for the networks will be organized on a regional and national scale by the CCC´s. The networks who were involved in the review will support there collegue-networks by bringing in there expertise. Nationwide implementation will be organised in trances and will take a period of 2-3 years. Meanwhile the process will be followed by evaluation research.

PE 1.F260

Assessment of the needs for palliative care at Keio University Hospital - Survey of medical professionals and patients

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Background: Prior to the start of operations by the palliative care team (PCT) at our institution, the current recognition of and attitude toward palliative care and needs for consulting the PCT of physicians and nurses (medical professionals) as well as the needs of cancer inpatients were comprehensively assessed to determine the required interventions by the PCT.
Methods: Questionnaire surveys of 1) medical professionals and 2) cancer inpatients were conducted. The questionnaire of patients included the M. D. Anderson Symptom Inventory, the Hospital Anxiety and Depression Scale, the Scale of Worry, and a questionnaire on the awareness and utilization of related in-hospital services.
Results:
1) Over 90% of medical professionals were "not satisfied" or "slightly satisfied" with the current palliative care conditions. The improvement of knowledge and ability to provide palliative care, coordination of the location of medical care and mental care of the family were most commonly mentioned. They expect the PCT to play a key role in: management of pain and other physical symptoms, mental/psychological care, and providing education for palliative care.
2) As for the patients, their main concerns and symptoms included distress, lack of appetite, drowsiness, sad feeling, dry mouth and pain. Opioids were used by 12.1% and the in-hospital pain clinic was used by 6.5% of the patients.
Conclusions: The survey findings revealed that the current palliative care services must be improved and the PCT is expected to fulfill those unmet needs; that is, to alleviate the physical /mental symptoms of patients, and actively engage in counseling for the family, when necessary. In response to those findings, a palliative care clinic for outpatients will be established in the Oncology Center. Moreover, palliative care workshops for medical professionals will be held regularly to provide a certain level of palliative care in clinical practice.

PE 1.F261

Home-based palliative care services for underserved populations

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Aim: Kokua Kalihi Valley is one of the first federally qualified community health centers in the United States offering home-based palliative care (HBPC). We serve low income, immigrant populations from Asia and the Pacific Islands, whose end-of-life needs are poorly understood. Our team includes a palliative medicine physician, nurse, case manager, psychologist, interpreters and volunteers. The purpose of this institutional review board approved study was to measure symptom relief and quality of life, resource utilization, and satisfaction with HBPC.
Methods: From 1 February 2007 to 2008, 46 homebound people with chronic advanced illnesses were enrolled. Data were collected prospectively, upon admission and repeatedly thereafter, using the Missoula-Vitas Quality of Life Index, the Edmonton Symptom Assessment Scale, and the Palliative Performance Scale. Utilization of resources was tracked, including case management, hospice, emergency, and hospital visits.
Results: The median age was 71 years, and more than half had chronic neurodegenerative conditions. The most common ethnicities were Samoan, Filipino, Japanese, Micronesian, and Hawaiian, accounting for 87%. Median stay in the program was 7 months, with a median of 3.5 visits. Preliminary analysis reveals high patient and caregiver satisfaction with HBPC. The percent of patients with "minimal" pain (score <3) increased from 57% to 71%. Discussions and documentation of end-of-life wishes rose significantly from 50% to 90% ($p<0.01$). The median time in hospice was 67.5 days. The percent of patients with no emergency room visit rose from 41% to 67% ($p<0.01$).
Conclusions: Data on outcomes research and quality indicators of HBPC programs is scant. We present data on a population of immigrant Asian and Pacific Islander patients. Our experience demonstrates the effectiveness of palliative care approaches in this population.

PE 1.F262

Palliative care initiative in United Arab Emirites - A unique experience

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United Arab Emirates (UAE) is a small Middle Eastern country on the Persian Gulf with 4.3 million populations. The population compromises of 15% native and 85% expatriate workers from all over the world and manly from Asian countries. All patients with cancer diagnosis are provided with free treatment. Previously cardiac disease were considered the major cause of death in the country but a recent survey revealed that Cancer is the leading cause of death (20%) followed closely by accidents (19%) and heart diseases(12%).
In Jan 2007 Tawam hospital Johns Hopkins Medicine decided to start the first organized Palliative care service of the country. This hospital is the tertiary care cancer center with 812 cancer patients treated at this center in year 2006.
Plan was made to develop a fully function Palliative care service over a period of 6 months. Initially a consultation service was started in February 2007 with intensive education for all health care workers. After two months an outpatient clinic and finally and inpatient unit (5 beds) is stated at the end of the six month. In first month only 5 patients were referred to

the service and with education there was gradual increase in the number of consultations to 51 patients in December 2007.
Total 243 patients were treated by the Palliative Care service in 2007. The majority of cancer patients are expatriate with ratio of 2.3: 1 to the native cancer patients. The end of life problems in expatriate cancer patients is very different from native cancer patients. The expatriate have limited social and emotional support as they are either single or small family units. The anguish of dying away from home and in a foreign land increases their suffering. The native cancer patients have support of extended families and social network.
The social , psychological and emotional issues in the expatriate cancer patients in UAE need further studies.

PE 1.F263

Carcinoma of unknown primary. Which MDT?

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Background: Approximately 60 patients present each year with metastatic cancer of unknown primary(UKP). Many present as emergencies and a diagnosis is made within 24hours following basic imaging. Prognosis for majority of UKP patients is poor and can be estimated from presenting signs,symptoms and fitmess (performance status). Current practice shows us that these patients undergo extensive uneccesary investigations to hunt the primary, that delay referral to Palliative care and oncology. Investigations obstruct open discussion with patients re likely diagnosis and prognosis .Because of the unknown primary site they are not presented in any multi-disciplinary cancer team meeting (MDT).
Aim: To design an UKP pathway in an acute district general hospital aimed at early parallel referral to Oncology/Palliative care before investigation to instigate appropriate investigations and management linking into either Lung cancer MDT or Colorectal cancer MDT and thereby reducing unecessary investigations and facilitating early discharge for this vulnerable group of patients.
Method: During 3 month period a prospective survey was performed of all new UKP patients using the pathway.Referrals had a single point of access to UKP team and were coded by cancer services.Emphasis of management was guided by performance status(PS) and disease pattern.Patients who presented with disease above the diaphragm were listed in Lung MDT and those below the diagphragm in the Colorectal MDT.
Results: Findings show that time to diagnosis and referral to team are reduced.Average length of stay was halved.Using a named site specific CNS has faciltated the addition to current MDT discussion and resulted in targeted appropriate supportive care.
Conclusion: Development of simple model of care for vulnerable group of patients can reduce unecesary investigations and hospital length of stay. Further work on rolling out pathway network wide and nationally is in progress.

PE 1.F264

ANT Oncological Hospital-at-Home (ANT-OHH): Eubiosia project - An efficient model for the care of advanced and far advanced cancer Patients

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Introduction: The care of cancer Patients (median life expectancy 80 days) has dignity of life as its primary goal. Since 1985 the ANT Foundation has created the ANT-OHH, assisting these cancer Patients in their homes (EUBIOSIA PROJECT) with traditional hospital level.
Methods: The structural model of ANT provides the Patients and their families with a free-of-charge 24 hours social and health assistance. The ANT-OHH physicians, nurses and psychologists are organized in functionally autonomous professional teams based on the traditional hospital model. The acceptance of the Patients in ANT-OHH depends only on the diagnosis of cancer and the request of the G.P. All the professional staff is subject to basic and continuous training.
We are able to provide at home, a socio-sanitary assistance, including clinical, psychological and social support to the Patients and Families.
Results: 23 ANT-OHH are working now in 10 Italian regions, with 153 physicians (oncologist and other specialists), 2 nutritionists, 79 nurses, 23 psychologists, 3 physiotherapists, 3 pharmacists and 58 specialist consultants. Until June 2008 a total of more than 66.000 Patients were assisted in ANT-OHH, translating in an overall total of more than 10 million days of assistance. About 3.000 Patients are daily assisted throughout Italy, their median age being 75 years.
Conclusions: In its 23 years experience the ANT-OHH model fully replies to the needs of far advanced cancer Patients. The economic advantage of hospital-at-home care (30,00¤ /day the cost at home instead of 670,00¤/day in the traditional hospital) is certainly very important, but we would like to stress that better quality and dignity of life should be the main point supporting the idea of global hospital-at home care.

PE 1.F265

Palliative module for discharge managemnt system

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In DRG times an optimised patient flow creates better quality and economic surplus. Detecting patients with discharge problems well in advance during the hospital stay rather than prior to discharge enables the team to provide neccessary discharge support in time.
Therefore atleast after 48 hours after admission to the hospital doctors and nurses are required to fill in a discharge score card for each patient. If a discharge problem is detected the ´discharge manager´is informed and starts to plan the support needed.
One special "problem group" are palliative patients. In order to fill the need we designed a "p"palliative patient detection protocoll and score card". It comprises different items(reduced life expectation/non-curative treatment or curative treatment with low success/symptomcontrol neccessary/ insufficient support system so far). If in each sector a positive answer is found the discharge manager informs the palliative care team. It then delivers a palliative consultation for the patient. This has to take place within 24 hours after the request on week days. It detects special needs of the patient and it´s care from the palliative view point and gives valid information, support or transfer options to specialized palliative care services such as hospices, home care systems etc. The consult team consiste of a palliative care nurse and a doctor specialized in palliative medicine.
We hope to improve and to provide better service and support for our medical colleagues as well as for the patients and their relatives in order to reduce unneccessary duration of hospital stay and improvement of good quality service after discharge.

PE 1.F266

Palliative Medicine Outpatient Clinics (PMOC): Do different care settings influence the patients' experience of care?

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Background: Palliative care is provided in a variety of settings. As care is not context bound, palliative care teams currently form many guises within the hospital, hospice and community environments. A Palliative Medicine Outpatient Clinic (PMOC) exists to meet the flexible provision of the needs and preferences of individuals. In gaining patients' actual experience of care in preference to their satisfaction, it is a more accurate measure of how and what patients judge as important in their health care.
Methods: A naturalistic qualitative approach through semi-structured interviews was employed.Interviews were conducted with patients and clinicians from a variety of settings and they were tape-recorded, transcribed verbatim and analysed thematically.
Results: Participants(n=14) were keen to tell their story and share their experiences from initial 'thought' or 'expectation' about the clinic to why they 'needed' to keep attending the service. Clinicians had similar 'philosophies to care' and saw the clinic as a 'portal' to other services and 'pivotal' in facilitating health literacy and patient engagement. Participant's expectations and experiences were grouped within the key themes of 'Experience of care', the 'Doctor-Patient interaction' and the 'Perceived Valve/Impact' from attending the clinic.
Conclusions: Palliative Medicine Outpatient Clinics (PMOCs) are a key 'portal' for patients and carers to access palliative care services. The experiences of patients, the 'philosophy of care' by clinicians and the considerable challenges in trying to quantify what measure of utility or effectiveness is gained by patient or professional are similar irrespective of setting. The steadfast challenge for palliative medicine is to capture the essence of our practice in a way that can be translated,so services can be commissioned in this current climate of fiscally driven markers of care that struggle to reflect the 'quality' of individualized care delivery.

PE 1.F267

Organizational structure of palliative care services in Georgia

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Cancer Prevention Center is the founder of Palliative Care Services in Georgia. In 2004 it has founded first inpatient hospice (for 18 beds) providing full scope palliative care (medical, psychological, social, and spiritual) to incurable patients and their family members. Next to the practical activities, cancer prevention and palliative care regional resource-training center conducts seminars and workshops for health care professionals from Caucasian countries. Most important organizational activities of the Cancer Prevention Center: 2006 - Foundation of Palliative Home Care service (serving 50 patients at a time) in Tbilisi and a hospice in Batumi (Adjara Autonomous Republic); 2007 - Palliative Home Care service and consultation service for cancer patients of local oncological clinic were started in Batumi. The aim of the service is to provide consultations to health care professionals, cancer patients and their family members after their discharge from the hospital. 2008 - Palliative Care service has been organized for HIV Patients in Tbilisi and three big cities of Georgia. The patients receive full scope care there. At present moment Cancer Prevention Center is working on establishment of pain management consulting rooms for provision of adequate pain management.
Conclusion:
1. Palliative Care system has been established and its consistency has been proved.
2. Future development of Palliative care infrastructure throughout Georgia is necessary to ensure its accessibility for the whole population in need of the care.

PE 1.F268

Volunteer work in palliative care: A comparison of 7 European countries

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Aim: To present an overview about volunteer work in seven European countries.
Method: Data was gathered as part of a European project funded by the PHEA (EU) ´Best practices in

palliative care in Europe´. The 7 participating countries (NL, B, E, F, D, PL, ENG) worked approximately 2 month independently on the data collection. First, a grey literature search was performed. Additionally, expert opinions were asked in interviews or via e-mail. The amount of experts was limited to a maximum of 10 key persons, who should perform a complete and reliable overview of the organisations of care. The questionnaire which was used was prepared beforehand and included several questions concerning organisation, research and education in palliative care.
Results: There appeared to be many differences between the countries in the role volunteers have, their education, and whether or not palliative care is dependent of them.
Conclusion: This European comparison can be the first step to international exchange of knowledge and experience in the field of volunteer work.
Keywords: Volunteers, volunteer work, palliative care, organisation, Europe.

PE 1.F269

Palliative care research in Spain

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Aim: To describe the scientific activity in palliative care research in Spain, as measured by the abstracts submitted in four national congresses of Spanish Society of Palliative Care (from 2000 to 2006). A secondary aim was to evaluate quality of abstracts of two of the congresses.
Methods: 1069 abstracts accepted in the four congresses were analyzed. Data collected: number of authors, study design, setting/work center, issues. The quality of 602 abstracts presented in two of the congresses was evaluated. Subjective assessment included six items: study importance, interest, connection between title and contents, study design, result and conclusion significance. The six items were scored from 0 to 3 (total score range: 0-18).
Results:
Mean authors: 5.4(1-19).
Study design: 452(42%) descriptive, 224(21%) retrospective, 224(21%) prospective, 22(2%) others.
Setting: 175(16%) Home Palliative Care Team, 434(41%) Palliative Care Unit, 129(12%) Medical Oncology Department, 154(14%) other hospital departments, and 179(17%) others.
Topic areas: 234(22%) organization, 69(6%) pain, 186(17%) other symptoms, 106(10%) complementary therapies/treatment, 101(9%) pharmacology, 51(5%) family, 322(31%) others.
Obtained mean scores: importance 1.3, interest 1.2, connection to title 1.7, design 1.2, results 1.0, conclusions 1.0. Mean total score obtained was 7.5.
Conclusions: Only 21% of the studies were prospective. Palliative Care Units presented most of the abstracts. Organization and health system issues were common topics. Mean total score obtained was low. Prospective and multicenter studies should be encouraged to improve research in palliative care and more stringent criteria for abstract acceptance implemented.

PE 1.F270

Network of resource nurses in cancer and palliative care: An evaluation study

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Aim: In 2006 a network of resource nurses in cancer and palliative care was established in our area, in cooperation between hospitals, health care authorities, 22 local communities, the Cancer Society, and the nursing college offering specialization in cancer nursing. The aim was to improve cooperation and continuity of care and disseminate palliative care expertise throughout the area. The resource nurses are engaged in local clinical services, coordination and system work, and give advice/instruction to their colleagues. The network is organized with a responsible steering committee, an executive committee, and resource nurses divided into 7 local groups meeting four times a year. The aim of the present study was to evaluate the network with respect to organization and main functions of the resource nurses.
Methods: Focus group interview with the executive committee (8 members), and questionnaires sent to the recourse nurses (83) and their employers (60). 59 nurses and 34 leaders returned the questionnaires.
Results: The resource nurses are highly skilled, experienced nurses. Even if they find their role as resource nurse somewhat unclear, they fulfil the main functions. However, they mostly work within their own units. The nurses experience some support from their leaders, but very few have time set aside for specific network tasks. The network structure and organization were evaluated overall as well functioning, but a closer link between the executive committee and the local groups was regarded necessary.
Conclusion: The network is established and well functioning, having an appropriate structure. The resource nurses fulfil their main functions. There are still some challenges connected to role clarification and guidance. The results show that the network improves cooperation and strengthens expertise in palliative care.
No external funding was received.

PE 1.F271

"It's a privilege really to be involved": Community nursing roles, relationships and identities in primary palliative care

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Aims:
- To explore the roles of community nurses in primary palliative care.
- To examine how professional identities and the quality of collaborative working impact on such roles.
Method: A qualitative approach was used to examine how different groups of community nurses saw their own and each others' roles in palliative care. The study was set in three areas with differing populations and health profiles. Two main groups of nurses were interviewed - district nursing team members (n=24) and community matrons (n=15). (Community matrons have case management responsibilities for patients with complex long-term conditions). The interviews were semi-structured and included an in-depth examination of one case from each participant. Interview transcripts were analysed thematically using the 'matrix' approach.
Results: Relationships between the two groups were problematic. Three factors influenced this: uncertainty about community matron roles, whether community matrons had local community experience, and whether other organisational changes had created tensions. All participants agreed that district nursing teams played a central role in primary palliative care. District nurses felt they had a case management role for these patients. However, community matrons raised doubts as to how effectively district nurses were able to fully carry out case management, because of the pressure on their time due to increasing workloads and the reactive, task-focused nature of their role. Community matrons saw the value of their case management skills for palliative care, but some district nurses saw little or no role for them in this area.
Conclusion: The case management skills of community matrons have much to offer primary palliative care, but this potential has not been realised due to the failure to effectively integrate their work with that of district nurses. A single integrated team structure could enable both groups of nurses to work more effectively to support patients.

PE 1.F272

Palliative care volunteers in a general hospital: What are their specific experiences, difficulties and satisfactions?

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Aims: According to the example of palliative care units and hospices, palliative care volunteers are increasingly present in acute care units in general hospitals. What are their specific experiences and work? We explored the characteristics of palliative care volunteer work in this particular context.
Method: Pilot observational study using a qualitative methodology. Various aspects of the volunteers' work and role were explored by means of a semi-structured questionnaire and a diary. Issues addressed concerned volunteers' activity (number and length of visits, topics of visits', etc.) as well as their motivations, their feelings, difficulties and satisfactions. Participants were palliative care volunteers (N=19) working at a university hospital in Switzerland. After giving written consent, they first completed the semi-structured questionnaire at home and then the diary every working day for one month. We used content analysis to generate main categories of answers in order to highlight the principal sets of themes reported by the volunteers.
Results: Results indicate that the main difficulties met by the volunteers were related to the complexity and the variety of situations - patients with various diseases at different stages -, and to the patients' short length of stay. However, they derived great satisfaction from the relationship they had with the patients, and most of them reported that they received more than they gave. Volunteers' work and experiences also appear very similar to those described in palliative care units or in hospices.
Conclusion: In spite of difficulties palliative care volunteers seem to have found their place in acute care units in a general hospital. This achievement was made possible in large part by a rigorously defined working framework.

PE 1.F274

Palliative care for mentally disabled people

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Aim: Any professional working in an institution for mentally disabled people will one day be confronted to a resident's end-of-life. Based on this fact, Palliative Care Vaud (Cantonal program for developing palliative care) has set this issue in its priorities. Within the canton, there are 19 institutions for mentally disabled people, representing 1300 residents.
Objectives: Develop a pc approach culture in institutions for mentally disabled people Facilitate and improve accessibility to pc services for this population. Improve continuity of care between place of residence and care settings (general or pc structures).
Methods: Considering the specificity of the mental disability domain, Health Care Vaud (Cantonal Department of Public Health) has established a partnership with a specialized educator, who collaborates with the 4 pc mobile teams. Her tasks consist of:
- Collecting data and create an inventory of actions already going on in those institutions
- Discussing their further specific needs
- Explaining the possibilities for developing an institutional palliative approach and provide support for the various pc projects
- Developing a inter-institutional collaboration for empowering the pc resources professionals involved in pc projects
- Contributing to develop palliative care basic education programs in the field of mental disability.
Indicators
- Number of professional trained at levels A and B
- Number of institutions which developed pc projects
- Number of mentally disabled patients who accessed to specialized services.
Results: The project started in February of 2008. First results will be available end of 2009.
Conclusion: The importance of a palliative approach in institutions for mentally disabled people seems obvious. Nevertheless, it will be necessary to allow time for these institutions to fully integrate this approach. The project will therefore extend over a period of 5 years.

PE 1.F275

An overview of palliative care in England, an EU perspective

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Background: There is an urgent need to evaluate and improve the quality of palliative care and to establish indicators for the quality of palliative care in Europe. In cooperation with 7 participating partner organisations in 7 European countries (Belgium, England, France, Germany, Netherlands, Poland, and Spain) an international study is being undertaken in order to

describe 'best practices in palliative care'.
Aims: To describe how palliative care is arranged in England (All participating countries will provide an overview of palliative care organisation in the participating countries).
Methods: All participating countries have filled in a questionnaire with organisational aspects of palliative care in their country, in order to get a broad view of several aspects of palliative care, mainly on a national level. For England a total of 28 participants were invited to complete an inventory, 10 participants agreed to take part. All communication was via email. A review of the literature was also undertaken on the organisation and funding of palliative care in England.
Results: Data has been collected and will be presented for England on the following; history of palliative care; NHS as it is relevant to palliative care; funding; policy; barriers and incentives; availability of drugs; role of volunteers; models and organisation of palliative care; education and research.
Conclusions: Following a review of the relevant research literatures and an inventory of the national quality indicators and guidelines for each participating country, a framework and set of international indicators will be established and rated following a Delphi procedure. The set of indicators established will be used to assess palliative care, define best practices and compare specific aspects of the palliative care provided both within and across the seven European countries.
Funding: EU supported via the PHEA (Public Health Executive Agency) in 2007.

PE 1.F276

Differences in place of death for cancer patients in two adjacent counties in Norway from 1996 to 2006

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Background: The majority of people want to be cared for and die at home. In spite of these wishes, most of the people dying due to cancer, die in an institution. The organisation of the health care system has been highlighted as a major contributing factor to the actual place of death. After 2001, two ambulant palliative care teams were established in one county (West-Agder) of Southern Norway, whereas this was not the case in the neighbouring county (East-Agder).
Aim: Describe the numbers of home-, hospital- and nursing home deaths over time in West- and East Agder. Highlight how organisational change of care in one of the counties influenced place of death.
Method: Official statistics for cancer patients were analyzed. Five (96-00)- and six year (01-06) files on home -, hospital - and nursing home deaths for all 30 municipalities in two neighbouring counties were analyzed. Differences in place of death in relation to distance to hospital and access to palliative team were compared.
Results: In West Agder, home - and nursing home deaths rose from 14-18% and 24-30%, respectively. In line with this, the number of hospital deaths declined from 60-51% (p< 0,0001). In East Agder no significant changes were observed.
Long distance to hospital was inversely related to hospital death and visa versa with nursing home death (p<0,05).
Conclusion: Two palliative teams were established in West-Agder during the period that was studied, whereas this was not the case in East-Agder. A significant increase in home- and nursing home death is observed in West - but not in East - Agder from the first to the last period. Establishment of palliative teams has probably contributed to a better coordination and end of life care for cancer patients. These results support previous reports, suggesting that the organization of health care systems and not patients preferences is a major determinant for place of death.

PE 1.F277

The development of palliative care (PC) services in Kaunas Nursing Hospital

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Kaunas Nursing Hospital was established in 1993 by initiative of charitable organisation "Caritas" to provide PC services to severely ill. It was one of the first nursing hospitals in our country; 1996 y.-5 nursing hospitals, 2007-59.
We became a honorary member of the Information Service of St. Christopher Hospital in London (1993). Mme Cicely Sounders visited us in 1996. Our physician M. I. Poniskaitiene became the member of International Institute and College in USA in 1998.
The priority for hospitalization is given to cancer patients and those who are lonely and homeless. Patients suffering from the last stages of cancer and neuromotoric diseases make one third of the overall number of patients hospitalized. The index of hospital lethality was 36,1% in 2005 and the index of cancer lethality was 56,4% (in 2006-39,1% and 49,5 %).
Number of patients who need palliative care is growing constantly. Possibilities to answer to these needs are not sufficient. During 2004-2006 year 1974 patient applied for services into Kaunas Nursing Hospital, 536 of them - for PC services. 50 percent of registered patients were not hospitalized. 23,6 percent of them chose other hospitals, 25,2 percent refused for the hospitalization, 40,1 percent died at home, for 11, 1 percent reason was unclear.
We use following principles of PC: enhancing the quality of life; conditions to die with dignity; multidisciplinary team work; symptoms control; the patients and his family is a whole; coordination of care with Home Care Service; prophylaxis of "burn out" syndrome.
We try to meet the medical, social and spiritual needs of patients as well as we can. The priest of the local parish celebrates the mass and there are other services provided according to the needs. The students of Priests' Seminary help to enhance spirituality of staff and the patients.
After legislation of PC services we have wider possibilities to optimize the needs of patients.

PE 1.F278

The challenge of creating a palliative care unit in a university hospital

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Describing the characteristics of patients admitted to the Palliative Care Unit (PCU) during the first 5 months of work.
Data were prospectively registered and have been collected from clinical charts. Administrative, clinical, symptom-related, information and family data are considered. 67 patients have been admitted (23% of the PCS activity). Main diagnostics are lung cancer (25.71%), brain cancer (12,86%) and colo-rectal cancer (7,14%). 67,14% are men, mean age 67,54 years old. 70% referred from Oncology Service (70%) and Emergency Room (ER) (10%). 38% have had a previous contact with the PCS. Mean stay at PCU is 11.23 days. Most die at the PCU (65.71%), 17.55% are transferred to hospice and 17,55% are discharged home. Median number of uncontrolled symptoms at admission is 4 of the 12 systematically explored symptoms (ESAS, constipation and dry motuh). Most prevalent are: asthenia (70%), pain (58%), anorexia (56%), dry mouth (37%) and drowsiness (36%). Somatic (38%) and visceral pain (33%) are the most common types. 33% have an Edmonton II pain. Only 18% are admitted in the terminal phase (death to be occurred in 7 days from admission). Mean Barthel 20, mean Karnofsky 40%. Mean Pfeiffer test: 2.6 mistakes. Most live with couple (52%) or with couple and sons (22%). 72% refer to have good family relations. Valid carer in 37%. 24% of the carers have emotional limitations and 13% physical limitations. 36% are fully informed meanwhile 17% are not.
The profile of our patient is a 67 year-old man with 4 uncontrolled symptoms, with poor performance status, without cognitive failure, who lives with his family with good relations to them and who is informed of his clinical condition.
Although a minority of patients is admitted in the terminal phase, 66% die at hospital. This is attributed to far-advanced disease at admission and delay to transfer to hospice. Intervention of the PCS at the ER may offer a faster and earlier integral management of the patient.

PE 1.F279

Patient and carer perspectives of palliative care in an acute hospital setting

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Aims: Patients with cancer and progressive illnesses are often admitted to hospital in the last year of life, however there is a dearth of studies of user views of hospital specialist palliative care services (SPCS). Study aim was to describe what patients and carers identify as important in receiving specialist palliative care in a hospital setting.
Method: Sample: 12 patients and 10 family carers referred to the SPCS in a large acute hospital trust in south of England, recruited on discharge from SPCS. All had three or more contacts with SPCS for symptom control/psychological support.
Data collection and analysis: Semi-structured interviews with patients and carers covering three broad areas; how they came to be referred to the SPCS, their views of using the service and its impact on their care in hospital. Interviews were audio taped and transcribed verbatim. Data were analysed thematically using framework analysis.
Results: Patients experienced shock, uncertainty and vulnerability in the unfamiliar hospital environment. The continuum of support offered by the SPCS was important and valued; basic courtesies like introductions, inclusive care involving active listening and attention to patient and carer priorities as well as complex interventions for difficult social and emotional circumstances. Symptom control input was mainly needed for pain. Patients cared about the process of symptom control but often did not fully recognise the role of SPCS in this. Some were too unwell to think about it, left it to the doctors or were just 'glad to have it sorted'. Carers were at a distance; often physically and geographically but also by not being fully aware of input.
Conclusion: Patients and carers identified the inclusive, individualised approach of the SPCS as highly valued giving patients and carers a sense of worth in the pressurised hospital environment. Awareness of their role in symptom control was less clear.
Funding: Charitable Trust Funds.

PE 1.F280

The introduction of a cascade model of education and support to facilitate use of the Liverpool Care Pathway for the dying patient within the care home environment

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Aim: This project provides a positive example of collaboration between two major organisations involved in both palliative care and care for the elderly. The aim was to introduce and evaluate the impact of a specific model of education and support provided to Care Home staff in the introduction of the Liverpool Care Pathway for the Dying Patient (LCP) within England. A cascade approach was adopted during the pilot phase of a larger project aimed at facilitating the phased implementation of the LCP into 125 Care Homes across the UK.
Methods: A total of 7 nursing Care Homes participated within the pilot phase. A local Key Champion (KC) and 2 Regional Project Leads (RPL) from a Central Team were appointed to lead implementation. A base line review of documented care for dying residents was obtained. Bi monthly meetings were held between the KC and the RPL. The meetings consisted of both group reflection and individual Care Home visits. Qualitative data was obtained using reflective diaries and focus groups, quantitative data, with the use of standardised documentation aimed at identifying progress, current status and specific implementation issues. All further contacts by the RPL were also documented. Data was evaluated by a National Central LCP Research and Evaluation Team.
Results: The model directly influenced a number of key areas relating to the introduction of the LCP for the dying resident; change management, progress of implementation, professional communication and staff confidence. Areas for further development were identified.
Conclusion: The pilot phase of this project has identified a model which provides appropriate support and demonstrable benefits for residents, families, staff and organisation. An adapted version of this model will

now be introduced into the second phase of LCP implementation. Further work is planned to ensure sustainability of the LCP following the use of this model.
Project funded by BUPA Giving.

PE 1.F281

Exploration of needs and experiences of patients, families and medical staff to inform a palliative care service in Bangladesh

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Background: Needs assessment is crucial to development of palliative care services. WHO recognizes and strongly supports expansion of palliative care worldwide. However, it recommends that the services need to adapt to the special needs in resource poor settings. It also acknowledges the lack of research in those countries as one of the obstacles in providing an efficient service.
Aims and objectives: The aim of this study was to assist the palliative care movement in Bangladesh to identify success and failure in order to deliver a more effective care to patients, and plan future developments.
Study design: Cross-sectional qualitative interview study.
Methods: Service providers as well as service recipients were interviewed about their palliative care experience and needs. Semi-structured interviews were carried out using a local interpreter.
Data analysis: Content analysis was performed. Transcripts were organized into general themes, and then categories of data were allocated to each theme.
Results: palliative care needs encompassed all the well known domains, physical, psychosocial and spiritual. However, pain control and need for morphine were the dominating feature in all interviews. Anger and mistrust towards health care system and health professionals were the unexpected findings in service recipients. Adequate information, but also compassionate and caring communication were regarded essential. Palliative care staff looked up specially to India as a role model. Lack of awareness in public and professionals was seen as the major barrier. Lack of availability of morphine was identified as the main barrier to pain control.
Conclusion: Palliative care needs in Bangladesh are in their content no different to developed countries, however, the magnitude and intensity of problems and their impact are overwhelming. Cancer experience is shadowed by poverty and low education/illiteracy, but also social injustice and inequality. International attention and collaboration with government of Bangladesh is needed to simplify narcotic regulations and make morphine available. For a wider coverage of palliative care and its expansion to rural area innovative ideas and strong advocates are required.

PE 1.F282

Palliative care social worker: A pilot post to establish the role

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Background: Historically the Palliative Care Service had not benefited from a dedicated social worker in either the inpatient unit, hospital or community team. The NICE guidance (2003) for Supportive and Palliative Care recommend that to provide specialist palliative care, teams require input from a social worker. A project was designed to pilot the role, within an established team.
Aims:
• To define the role of the social worker within the palliative care service.
• To determine the acceptability of the post to patients, carers, health and social care professionals.
• To establish the benefits of the role.
Methods: A steering group was formed with representation from social services, specialist palliative care service, primary care trust and acute hospital. A social worker was seconded to the post for one year. The pilot was evaluated with:
1. Focus groups with health and social care professionals, patients and carers.
2. A patient / carer satisfaction survey.
3. Activity data collection.
Results: Focus group themes:
• Continuity care between social services and health funding and between care locations
• Coordination of care
• Advocate and support for carer
• Signposting / resource for healthcare professionals
• Involvement in rapid discharge planning and prevention of readmission.
Satisfaction survey: 100% respondents reported high (>8/10) level of benefit from social worker input. 50% wanted the social worker to have been involved earlier in their illness.
Activity data: 160 referrals in one year. Reasons for referral: discharge planning (26%), family / carer support (18%), financial advice (25%) and crisis intervention (31%).
Outcome of referrals: 21% helped prevent hospital admission, 19% facilitated discharge, 47% ongoing psychological support.
Conclusions: A post previously considered unnecessary has been shown to be valued by patients, carers, health and social care professionals.

PE 1.F283

Domiciliary palliative care service of a palliative care unit in Brazil

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Research aims: In the Palliative Care Unit of Instituto Nacional de Câncer (INCA), about 250 patients are taken care in the domiciliary service with de goal of reducing hospitalization and improving patients quality of life with their families when they require considerable assistance and frequent medical care.
Study design and methods: We will describe our service and define our patient profile after collecting dates during a period of 18 months. A team member collects information in their first visit using a specific framework and the results are analyzed every month with the whole team.
Results: This domiciliary care service is responsible for a multiprofessional assistance (physician, nurse, social worker, psychologist and physiotherapist) for these patients, embracing an area of 50 miles distant from the hospital divided in 5 regions, each one with a team of reference.
The service receives every month about 100 new patients, all of them with a performance status under 50%. Physicians are supposed to make their first visit into 5 days after they are referred to the service, when their needs and prevalent symptoms are defined and a therapeutic plan prepared.
Nurses are supposed to visit them at least every 5 days to assure that required home assistance in been given, that caregivers are able to give adequate daily support, skin care and also to proceed specific non pharmacological therapeutically approach to prevalent symptoms.
Social worker helps to identify aim caregiver, gives orientation about their rights and legal responsibilities and is able to return to their houses always when identified their need by any other member of the team.
Conclusion: The aim of the domiciliary palliative care is to accurate the multiprofessional assistance in agreement with our patient profile for the adequate symptom control and improvement for the patient and family/ caregivers' quality of life minimizing bereavement problems.

PE 1.F284

Palliative care services: A proposal for Portugal

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Using as methodology, the protected referencied for Goméz-Batiste, Frank Ferris, Herrera, Rocafort, Clark, Stjernsward, Higginson, among other, we create for Portugal a proposal of net of palliative care services. This proposal has about guiding points: the estimate of patients that you/they would need palliative cares, be oncologic or not oncologic, the number of beds, the number of you equip, of the several typologies, the number of doctors and of necessary nurses. This way, with base in the population of 2007 and died on that year, we need, for Portugal, in medium numbers:
• 62107 patients to need of palliative care
• 14492 patients oncologic to need of palliative care
• 9290 patients no oncologic
• 21738 complex palliative patients, as well as the same number of no complex, and intermediate or agonic
• Need of 1062 beds • 319 beds in units of health for patients " sharp" or units for patients of larger complexity
• 531 beds in units for sick crónicos, or of intermediate complexity
• 239 beds in nursing homes
• 133 teams of community support
• 102 teams of hospital support
• 27 teams in units for acute patients or for patients of larger complexity
• 44 teams in units for chronic patients or of intermediate complexity
Medical:
• 265 in teams community support / domiciliary
• 204 in teams hospital support
• 93 in the units of acute patients
Nurses
• 465 in teams community support / domiciliary
• 357 in teams hospital support
• 239 in the units of acute patients a day.

PE 1.F285

Cross sectional study of acute hospital referrals to the palliative care service

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Hospital Palliative Care services are used with increasing frequency. We aimed to assess the distribution of referral sources to palliative care, identify the reasons for referral and the areas of need. Referral forms over a 3 month period were retrospectively analysed, looking at the source, the reason for referral, and the symptoms where relevant. 51.6% of referrals came from oncology, 26.9% from acute medicine, 10.8% surgical, 4.3% geriatrics, 4.3% haematology, 1.1% gynaecology, 1.1% paediatrics. 41.9% were referred for symptom control, 20.4% home care, 10.8% end of life care, 1.1% discharge planning, 8.6% home care follow up and symptom control, 3.2% discharge planning and symptom control, 6.5% other, 7.5% not documented. Symptom management accounted for 75% of Geriatric, 50% of Surgical and Haematology, 41.7% of Oncology, and 36% of medical referrals. End of life care accounted for 30% of surgical, 25% of Geriatric, 20% of medical and 2.1% of oncology referrals. Of 27 referrals involving a request for home care follow up, 21 came from oncology, 5 medicine, and 1 surgery. Among patients with malignancy the most common reason for referral was symptom control (43.2%), while among patients with non-malignant disease the most common reason for referral was for end of life care (41.7%). 50 referrals involved symptom control, 24 of which were for a single symptom, 11 for multiple symptoms. In 15 the symptoms were not specified. The most common symptom was pain. Oncology, who refer to the service most often, tend to refer more frequently for home care follow up than end of life care, suggesting they may involve palliative care at an earlier stage in the disease trajectory. It is encouraging that the most frequent reason for referral among 5 of 7 specialities was for symptom control. A large proportion of surgical referrals were for end of life care. Some teams refer infrequently, suggesting that there may be scope for further use of the palliative care service.

PE 1.F286

Acute care palliative medicine and discharge planning

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Aims: We used electronic databases to report:
1) Patient characteristics in an acute palliative medicine inpatient unit
2) Post acute care (PAC) service utilization
3) Factors influencing discharge planning.
Methods: Retrospective electronic databases analysis of 2006 & 2007.
Results: 1634 admissions. 52% Female; Median age 62 (20-99); 56% Married, 19% Single, 14% Widowed, 10% Divorced; 27% African-American, 70% White. Length of stay (LOS): Median 8 (range 1-103 days). Admit source: Clinic Referral (62%), Emergency Room (21%), and Hospital Transfer (17%). Payor source: Commercial (38%), Medicaid (9%), Medicare (47%), and others (6%). Readmissions (13%). Discharge dispostion: 21%

Expired, 18% Home with outpatient follow-up. 61% needed 1 or more PAC services. 1802 PAC services (Patient N=1003) were provided: 34% Hospice-home or inpatient (HOS); 14% Home Healthcare Agency (HHA); 13% Skilled Nursing Facility (SNF), Sub-Acute, Long Term Acute Care, Extended Care Facility; Additional PAC services: home infusion pharmacy, durable medical equipment, durable medical respiratory, home IV antibiotics, transportation. Need for more services predicted by: longer LOS, readmission, Medicare/Medicaid insurance, higher case mix index (CMI), admission from Emergency Room or a Hospital Transfer. Longer LOS predicted by higher CMI, Hospital Transfer, Medicaid. Readmissions predicted by being young and single. Predictors of discharge referral: sickest go to SNF or inpatient HOS; females more likely to receive HHA; patients referred from other units more likely to go to inpatient HOS.
Conclusions: Electronic data bases help appraise and identify consistent predictors for discharge planning and PAC utilization. These findings should
1) advance hospital throughput,
2) help determine patient PAC service needs,
3) improve discharge process efficiency,
4) enhance operational viability of an inpatient palliative medicine unit.

PE 1.F287

Finding the right information about palliative care services

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The database 'Zorg Kiezen' (pick and choose care) offers accurate and current information about palliative care services in the Netherlands.
In Netherlands the institutions that provide palliative care work together in regional palliative care networks. A best practice website of one of these networks is used to develop a design for a regional website. Networks start a website with this design and supplement it with their own (regional) information about palliative care. Information about palliative care services is an important part of the regional site. For this purpose the national database 'Zorg Kiezen' is developed. On established lines information about palliative care services is saved in the database and published on the regional site and several national sites (for example http://zorgkiezen.palliatief.nl). Through Google Maps visitors can search services in the national database in a specific area around a given place.
At this moment 66 of the 70 palliative care networks in the Netherlands (almost 95 %) participate in this system of regional sites and database 'Zorg Kiezen' and actualize on a regular base information about palliative care.
The database contains data about more than 500 palliative care services, such as inpatient palliative care units, hospices and home care teams. Details of the services such as the professionals working in the service, the care provided, number of beds, etc. are saved in about 75 fields of the database.
All this means that caregivers, patients and family can refer to accurate and current information about palliative care in the Netherlands through the database 'Zorg Kiezen' and the regional sites of palliative care networks. The database is appropriate for further research.

PE 1.F288

Pharmacist actions in a home care service of palliative care unit: A new look

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Introduction: The pharmacist has a key role in respect to the medication utilization ensuring therapy adherence. Factors such as low education level, as illiteracy and/or cognitive deficits of patients or their caregivers undertake adherence to treatment. Within this context of safe and rational use of medicines, the pharmacist is an important member of interdisciplinary team of Palliative Care. An area with a population of 21 patients was chosen to deploy the project to Pharmaceuticals Visit at home.
Objective: To identify the benefits to patients and caregivers through the Pharmaceuticals visit at patient's home.
Method: It was developed as a tool for data collection a questionnaire, through which the pharmacist assesses the level of knowledge about drugs and verifies adherence to treatment. The caregiver and/or patient is interviewed by the pharmacist at the time of the visit, held together with the nursing staff, with an interval of 7 day visit.
Results: In a period of five weeks were performed 27 visits to 15 patients, where only 3 had no specific requirements for guidance. The results were: 11 orientations on how to administer the drug, identifying 2 occurrences of drug interactions that were modified after pharmaceutical intervention, adequacy of hours of administration of drugs for 5 patients, 4 orientations about the risk of keeping inventories at home and self-medication, 1 report of the Adverse Drug Reactions, 4 orientations to suit the storage of medicine, 2 guidelines on paper with daily drug administration and 1 about the danger of self-medication and utilization of phytotherapies without medical advice.
Discussion and conclusion: Preliminary results of this pilot project reinforce the importance of the pharmacist in an interdisciplinary team of health, allowing an exchange of experiences with positive results, leading to the correct use of medicines and contributing to therapeutic adherence, thus raising the quality of service provided to patients.

PE 1.F289

Pharmacist insertion in home care service of palliative care unit: A search for rational drug utilization

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Introduction: The Home Care Service in a palliative care unit has to provide a family living with an adequate quality of life for terminals patients. In these patients, polypharmacy is often necessary, however, predisposes them to drug interactions and other adverse events, also facilitated by advanced age and comorbidities.
Purpose: To encourage the rational use of medicines, proving the importance of the pharmacist for the home care sector of the palliative care unit.
Method: A retrospective study on pilot scale, in the drug utilization in the unit, through the assessment of 192 prescriptions in 2005, comparing the results obtained for consumption in 2006, already with a pharmacist involved in sector. In none of the tests were considered discarding of drugs.
Results: We observed a marked reduction in the consumption of some items normally prescribed in home care, some of considerable price, such as fentanyl transdermal. From the comparison between the requirements of 2005 and 2006, we have seen that the overall economy was on the order of 20%, an important value within the Pharmacoeconomics context.
Discussion and conclusion: The pharmacist insertion led to a reduction in the amount of exempted products, providing financial benefits to the institution, and encouraging the rational use of medicines. The proximity between different health care professionals give more dynamism and facilitates the exchange of information, leading to early identification of problems related to drugs or adverse events resulting from treatment, regardless of their nature.

PE 1.F290

Infection control in palliative care: The action of the Hospital Infection Control Committee

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Purpose: To demonstrate the benefits of the actions of Hospital Infection Control Committee (HICC) activities in a palliative care unit, and its direct impact on patient care.
Approach: Descriptive study of the HICC activities of from September 2006 to September 2008, with the presentation of clinical indicators.
Results: The following actions were taken:
1. Construction of Indicator of AntibioticsXDeath utilization, which measures the percentage of patients who go to death in use of antibiotics, and were required within 72 hours prior to death;
2. Establishment of microbiological profile of the unit, with disclosure of periodic reports to the team;
3. Guideline for utilization of topical and systemic metronidazole in controlling the odor of wounds tumor.
4. A microbiological routine research in patient admission with to reduce the spread of multi-resistant germs;
5. Standardization and the adequacy of existing legislation procedures for cleaning and disinfection of materials, through the restructuring of the Central of Materials and Sterilization;
6. Preparation of routines for health professionals and several books for patients, caregivers and household companions hospital, with lectures and continuing education training.
This actions leads to:
1. Reduction in the overall rate of nosocomial infection of 4.7% to 1.7%,
2. Reducing of the utilization of AntibioticsXDeath of 20.86% to 11.9%,
3. Reduction of hospital Infections of the respiratory tract of 9 cases for 2 cases.
4. Reducing the incidence of multi-resistant germs in positive cultures of 55.3% to 20.4%.
Conclusion: Reduce the incidence and severity of nosocomial infection means many of these patients free of infectious complications, which cause suffering, increase the length of hospital stay and may even hasten death. We know that in palliative care, the goal is not to increase survival, but the contact with the hospital service can not be a risk factor for the reduction of survival.

PE 1.F291

Hospicecare in the Netherlands

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In 2007 seven hospice care facilities have kept up a registration of all of their patients from the moment of their referral until they were discharged. For this aim a web-based application was used, developed by the department of palliative care of the Comprehensive Cancer Centre IKO Nijmegen. Hospice care facilities in the province of Gelderland using this application in 2007, consisted of six palliative care units situated in residential care facilities (2) and nursing homes (4), one unit in a homecare guesthouse (just-as-home house).
Most patients referred for admission had a diagnosis of cancer (80%). Of them, 53% was female and the mean age was 75 years old. At the time of referral 56% of the patients stayed in a hospital, 29% at home and 6% in a residential care facility or nursing home.
In 75% of all referrals, patients were actually admitted in a hospice care facility. The main reason (63%) for cancelling a referral was the patient passed away before hospice care could be delivered. Another frequently encountered reason (17%) was admission in another hospice care facility.
Most of the included hospice care facilities have a waiting list. 25% of the admissions took place after the requested start date. In 50% of the cases waiting times varied between one and three days, in 41% between four and seven days and in 9% more than seven days elapsed before admission.
The median length of stay in the hospice care facilities was 34,4 days. The mean bed occupancy rate was 72%.
The patients saw an average of 5,3 caregivers (professional and volunteer) during their admission and an average of 1,4 medical technologies (e.g. ascites puncture or blood transfusion) were used.
Of the patients admitted in the hospice care facilities, 93% died eventually. The remaining patients went home (3,5%) or moved to another hospice care facility or nursing home (3,5%).
In 2009 we present figures of 2008 of 20 hospice care facilities in the provinces Gelderland and Limburg.

PE 1.F292

Hospice in Ivano-Frankivsk region of Ukraine: Step by step

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The first hospice in Ukraine.The history of Ivano-Frankivsk hospice began in July 1997, when a special decree was adapted by our regional health care

department and a separate building was given to the hospice.
At present the Ivano-Frankivsk hospice is a stationary hospital for 30 beds. The hospice team renders free daily palliative aid to the patients who are in the terminal stage of the disease. Most of the patients are adults with cancer and other diseases. Children are also hospitalized. Every year 250 patients are hospitalized in the hospice, every day we serve 30-32 patients.
We also give psychological support to the patients' relatives. Our team consists of 3 doctors, 14 medical nurses, 13 junior medical nurses, one social worker, hospice chaplain, 9 auxiliary workers. Besides, since January 2005 we have been consulting and treating patients at home, giving psychological and spiritual support to those who cannot be hospitalized. For this a special mobile group is organized. It works in Ivano-Frankivsk free of charge.Main problems and perspectives:
- opening of 60 additional palliative beds on Ivano-Frankivsk region (including 10 beds for pediatric oncology and 20 for AIDS patients)
- construction of a new building (search for sponsors and investors)
- creation of a palliative care model in the region
- creation of a hospice at home (there is a great necessary of it)
- creation of mobile consulting brigades to consult at other medical institutions
- development of volunteering
- scientific work and issuing manuals on palliative medicine
- expanding of palliative and spiritual programs to other regions of Ukraine.
Summary: Authors presented:
- short historical review of the development of palliative care in Ukraine and Ivano-Frankivsk region in particular
- important results of the process
- work of Ivano-Frankivsk hospice
- problems and perspectives in the further expanding of the service.

PE 1.F293

Economic effects of palliative care provided by a home care support team of an university hospital in Austria

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Introduction: The purpose of this study was to compare the financial impact of palliative care provided by a home care support team, with inpatient palliative care of cancer patients.
Methods: For this retrospective study two groups of cancer patients who had been admitted during 2005 and 2006 at least once to the ward of the palliative care unit, were defined:
1) an intervention group (IG) of patients (n=60) who received palliative care by the home care support team for at least 45 days in 2005 and 2006, and
2) a control group (CG) of patients (n=60) who received inpatient care only. All patients included in this analysis died in 2005 or 2006.
Patients of the two groups were matched according to age, sex and tumour type. Data of expenditures from all public federal state hospitals and datasets of the largest compulsory health insurance institute of the federal state, including follow-up costs were considered. Healthcare costs were allocated to expenditures for inpatient care, costs for outpatient care (general medicine, specialised medicine, drugs, assistive technology, patient transports) and costs of the home care support team. Healthcare expenditures in the two last months of patients´ lifes were compared between the IG and the CG.
Results: In the IG mean costs for inpatient care were statistically significantly lower compared to the CG (¤ 5,843 vs. ¤ 7,502 / -22.1% / p=0.035). Mean costs for outpatient care were statistically not significantly higher in the IG (IG: ¤ 1,391; CG: ¤ 1,106 / + 25.8% / p=0.063). Mean expenditures for the home care support team were ¤ 1,290 in the IG. Healthcare costs were approximately the same in the two patient groups (IG: ¤ 8,524; CG: ¤ 8,608 / + 1% / p=0.988).
Conclusions: Results of this study demonstrate that palliative care by a home care support team is self-financing due to savings in inpatient care during the two last months of life in cancer patients.

PE 1.F294

Physiotherapy service in a palliative care unit

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Background: The physiotherapy in the context of palliative care, aims to promote the likelihood of cure patients without the face of physical limitations resulting from the progression of the disease, through prevention, the proper control of the signs and symptoms and the principles of comfort and quality of life until the time of his finiteness. After the patient transfer to the origin clinic for the palliative unit, many are the challenges that extend in all processes of care. The unit offers the service in an outpatient, home care and inpatients, with a team of nine physiotherapists.
Objective: To present physiotherapy service in a palliative care unit in all processes of care.
Results: According to the clinical indicators collected from October to December 2007, the physiotherapy provided care to 343 patients in outpatient clinics, 171 in home care and 686 in hospital.
Each segment works seeking an individualized care, and within its own characteristics: at the clinic, patients have better KPS (Karnofsky Perfomance Status) allowing for greater intensity conducts and even physical reconditioning. With the evolution of the disease the patients are referred for home care in charge of guiding caregivers, to adjust the use of ortheses in their residential environment, train march, avoid osteomyoarticular and respiratory complications by the disuse syndrome and guide about the changes at home. The patients who have complications, or they need minor surgical interventions are sent to hospitalization, where the physiotherapy will be in control of signs and symptoms and measures of comfort.
Conclusion: The physiotherapy is indispensable both in the rehabilitation of patients in their daily living activities, restoring a sense of dignity and self-esteem by giving new goals as effectively acting in symptoms and discomforts of his specific pathology. Thus, there is a role of physiotherapy in palliative care service, adding excellence in the treatment.

PE 1.F295

A physician-driven workflow triage model used in an interdisciplinary palliative care community consult team

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Aim: Increasing workload and expectations against a background of nursing and physician shortages have prompted us to search for new models to improve the delivery of care. Striving to improve staff satisfaction and work/life balance were further motivating factors. We proposed a computerized physician-driven triage system as an alternative to the pre-existing nurse-driven model.
Method: We designed a computer program to capture the different aspects of patient consultation, such as referral request, date of service, patient demographics, responsible consultant and type of service provided. This program is now used by physicians to triage the workload in order to provide timely and appropriate medical care to our palliative patients in the community.
Results: We will report on the impact of this model on our daily workflow and workload. We will comment on the impact of this model on division of the workload, time availability for other scholarly activities (e.g. education, research), work/life balance, impact on allied health professionals, as well as staff satisfaction. We will discuss the future applications of the newly created data set.
Conclusion: This innovative model is one of the first of its kind and may have application for other Palliative Care programs that provide care in diverse settings. This system will be used in conjunction with SNOMED computer language to create a Palliative Care related vocabulary to enhance communication between different databases.

PE 1.F296

Needs assessment of palliative care in a rural setting: Data from South-eastern Bavaria

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Introduction: Most available data on palliative care service provision come from studies in urban settings. Our aim was to estimate the need for specialized palliative care services for inpatients and outpatients for three administrative districts in the rural region of south-eastern Bavaria.
Methods: A specifically developed questionnaire was sent to general practitioners and physicians in hospitals as well as to head nursing staff (in hospitals as well as in nursing homes and outpatient nursing services).
Results: 235 questionnaires were returned (150 physicians, 85 head nurses; return rates 38 and 71%, resp.). Most respondents reported lack of time (often 45%, very often 23%) and personnel. In the areas of pain and symptom management, advanced knowledge is lacking (e.g. only 15% of physicians use s.c. infusions, 58% have never or only rarely used benzodiazepines for dyspnea). 55% of general practitioners and 89% of emergency physicians stated that specialized outpatient palliative care teams could prevent unnecessary hospitalizations at the end of life. In self-assessment, 72% of general practitioners feel confident or very confident in palliative care. However, head nurses graded the physicians' competence only a 3.6 on a scale from 1 (very good) to 6 (insufficient). Existing hospice and palliative care services are highly accepted (collaboration: rather positive 29%, positive 66%). Still, the need for further palliative care services was regarded as high. Compared to physicians, nurses indicated an even higher need for further education in palliative care (pain therapy: physicians 48%, nurses 99%; communication skills: physicians 56%, nurses 99%).
Conclusion: By asking both doctors and nurses, we found clear evidence for a lack of palliative care services in rural areas. The results of our study show the existing knowledge gaps and the need for new services such as hospital support teams and specialized outpatient palliative care teams.

PE 1.F297

Developing a palliative care society for South Africa

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Aim: Whilst palliative care organisations had a national association in South Africa, no organisation existed for individuals who are not linked to these organisations. A Palliative Care Society of South Africa has been formed to promote, elevate and advocate for palliative care practitioners with the vison of "Palliative Care for All, by All".
Method: In 2005 the first meeting of intent was called in Johannesburg for those interested in developing a society to promote the interest of individuals in palliative care. A steering group was estalished with representatives from different organisations and provinces. The mssion of the Palliative Care Society of South Africa is to promote, elevate and advance the practice of palliative care in South Africa, through research, education, public awareness, a monthly newsletter, and local discussion groups. The first Annual General Meeting was held in Durban, and portfolios: Education; Children; Advocacy; Fundraising; Bio-Ethics; Communication established. The PCSSA works closely with the Hospice Palliative Care Association of South Africa and other oprganisations providing palliative care, but is not a palliative care provider itself.
Results: A strong and growing society to support individuals working in palliative care and to promote palliative care in South Africa.
Conclusions: National organisations should recognise the importance of professional associations for individual practitioners in palliative care.

PE 1.F298

Expanding the reach of palliative care in South Africa

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Aim: An evaluation of organisational development strategies of the Hospice Palliative Care Association (HPCA) to increase the reach of palliaitve care in South Africa.
Methods: In South Africa, Palliative Care has traditionally been provided by the NGO sector. The HPCA vision of ´Quality Palliative Care for All´ is only achievable through the integration of palliative care into all health care settings in South Africa.
This study reviews the different initiatives implemented by HPCA to promote the integration of palliative care into the formal and informal health care sector. The assessment tools for evaluation of health care service, mentorship activities and before and after competencies of health care workers are described against a background of advocacy in the development of palliative care policy in South Africa. Three different settings are used in the assessment : NGO supported by hospice, independent NGO, Government hospital. Quality of care as a measure of effective palliaitve care is documented through audit of services using the APCA African POS as an audit tool.
Results: Intergration of palliative care into the NGO sector is successfully documented, quality of care is dependent on support by hospice or HPCA staff. Hospital services are slower to integrate palliaitve care for a variety of reasons.
Conclusion: There is good support for the integration of palliaitve care into both formal and informal health care sector with many requests for mentorship received by HPCA. A successful model of integration has been developed and can be implemented in different health care settings.

PE 1.F299

Experience of switching from transdermal fentanyl, morphine or diamorphine to methadone: Can equianalgesic dose ratios be determined?

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Aim: Opioids are used in the management of moderate to severe cancer pain, morphine usually being the opioid of first choice. The role of opioid switching to improve pain control and toxicity has been well documented. Equianalgesic dose ratio information exists to guide conversion between most opioids, but there is lack of consensus with regard to methadone. For this reason an ad libitum schedule adapted from the Morley-Makin protocol is used by the authors, with methadone being individually titrated rather than calculated from a ratio based on the previous opioid dose. The aim of this study was to determine whether the day 7 methadone dose after switching could have been predicted from the final oral morphine equivalent daily dose (MEDD) of the prior opioid. The day 7 methadone dose was chosen as, in the authors' experience of using an ad libitum titration method, requirements tend to have stabilised by this time point.
Method: A retrospective analysis of medical notes was carried out for patients admitted to the hospice (1997 - 2007) for a switch from transdermal fentanyl (n=28), morphine (n=32) or diamorphine (n=15) to methadone. Reason for change, opioid doses and an estimate of pain relief were recorded.
Results: In most cases the documented reason for a switch to methadone was tolerance to the previous opioid. Median age was 56 years (range 22 - 74 years); male to female ratio was 1.2:1. The MEDD prior to switching ranged from 180mg to 3900mg with a median dose of 800mg. Analysis of the final MEDD and the total day 7 methadone dose from all 75 patients revealed a Spearman correlation coefficient of 0.23 (p=0.05). Pain relief was estimated as 'same' or 'better' in 94% of cases post switch.
Conclusions: The weak positive correlation between MEDD and the total day 7 methadone dose suggests the need for careful individualised titration rather than relying on equianalgesic dose ratios when switching to methadone.

PE 1.F300

Advantage of early induction of controlled-release oxycodone to control head and neck cancer pain caused by irradiation

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Research and aims: Radiotherapy for head and neck cancer usually induces mucositis, which reduces the quality of life (QOL) of patients by causing pain and interfering with eating. Moreover, ongoing treatment has to be interrupted. The comparative study of historical cohorts was performed to examine the effectiveness of early use of low-dose controlled-release oxycodone (CRO) in patients with mild pain.
Study design and methods: The patients were those hospitalized in our University Hospital with a diagnosis of head and neck cancer between April 2004 and March 2008. They were classified into the group with mild pain started on CRO (MILD) (n=52) and the group with moderate pain at the time CRO was started (MODERATE) (n=32). The control group (CONTROL) consisted of patients given non-opioid analgesics only, who were hospitalized in our University Hospital between April 2002 and March 2004(n=38).
Results: The dietary intake, calorie intake, and rate of patients on a regular diet decreased in all groups as the irradiation dose increased. The dietary intake and calorie intake were significantly higher in MILD than in CONTROL and MODERATE. The rate of patients on a regular diet was significantly higher in MILD compared with CONTROL and MODERATE after 25Gy, while there was no significant difference between CONTROL and MODERATE at a dose of 60Gy. The rate of weight loss was significantly lower for MILD than for MODERATE or CONTROL. The occurrence of side effects was similar in all groups.

PE 1.F301

Assessment of advanced cancer patients pain in Georgia

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Objectives: Although pain assessment is a vital preliminary step towards the satisfactory control of cancer pain, data on the prevalence of different pain syndromes are rare. The present study surveys 730 advanced cancer patients treated by a pain service following the WHO guidelines for relief of cancer pain.
Methods: In a prevalence study, ECOG performance status and visual analogic scale (VAS).
Results: From the start of the research, from 838 advanced cancer patients 730 (87,1%) had pain. From that, patients 294 (40,3%) had severe pain (VAS 0-3), 222 (30,4%) - moderate pain (VAS 3-5,5), 214 (29,3%) had mild pain (VAS 5,5-10). The mean point of pain in the patients (730) who participated in the research was 5,5 by VAS. From 730 patients with pain at ECOG scale I-II gradation was reveiled in 146 patients (20,0%), at scale III gradation - 221 cases (30,3 %), at scale IV gradation - 363 (49,7%). From 146 patients with pain at ECOG scale I-II gradation 8 (5,5%) had severe pain, 44 (30,1%) - moderate pain, 94 (64,4%) - mild pain; From 221 patients with pain at scale III gradation - 63 (28,5%) had severe pain, 88 (39,8%) - moderate pain, 70 (31,7%) - mild pain; From 363 patients with pain at scale IV gradation - 203 (55,9%) had severe pain, 95 (26,2%) - moderate pain, 65 (17,9%) - mild pain. 377 (51,6%) presented with nociceptive, 32 (4,4%) with neuropathic and 321 (44,0%) with mixed (nociceptive and neuropathic) pain. Analgesic treatment resulted in a significant pain relief in all groups of patients, as the mean pain intensity (NRS) decreased from 6,0 (nociceptive), 6,5 (mixed) and 7,2 (neuropathic) on admission to 2,0, 2,5 and 2,9 after 3 days and 1,0, 1,5 and 2,0 at the end of survey.
Conclusion:
1. The variety of pain syndromes evaluated in our patients confirms the importance of comprehensive pain assessment prior to treatment;
2. Cancer pain is not intractable and can be relieved in the majority of patients by treatment following the WHO guidelines.

PE 1.F302

Intercostal nerve block combined with pulsed radiofrequency in the treatment of intercostal neuralgia

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Introduction: Many patients suffer from intercostal neuralgia caused by metastatic cancer or thoracotomy. Intercostal nerve blocks are widely used to reduce the neuralgia symptoms. In general, an intercostal nerve block is performed using local anaesthetics. To obtain a prolonged nerve block effect, alcohol blocks or radiofrequency thermocoagulation are used as neurodestructive methods. These cause nerve injury followed by sensory disturbance. Pulsed radiofrequency (PRF) for neuromodulation has been applied to the dorsal root ganglions. This method produces pain relief without adverse side effects, such as neurological damage due to thermal destruction. The application of PRF to peripheral nerves is thought to be safer than nerve root blocks. We use this treatment for intercostal neuralgia on peripheral nerves to obtain effective pain relief with fewer complications.
Methods: We treated 4 patients with intercostal neuralgia caused by cancer or thoracotomy. They had been referred to us due to refractory pharmacotherapy. PRF treatment was done at a setting of 2Hz for 120 seconds at 20 ms current cycles on each intercostal nerve, using an insulated needle with an active tip. After the procedure, small amounts of local anaesthetics were injected to the intercostal nerves. We defined a clinically successful block as one achieving greater than 50% pain relief measured by visual analogue scale. We noted any adverse side effects, and interviewed the patients as to their satisfaction with the results of the treatment.
Results: All patients felt immediate pain relief after blocking. Three of the 4 patients have experienced lasting pain relief and have expressed satisfaction with the treatment. There were no severe adverse side effects. The one patient who was refractory to the PRF therapy had pleural dissemination.
Conclusion: Intercostal nerve block combined with PRF has the potential to be a useful technique for reducing intercostal neuralgia without adverse side effects.

PE 1.F303

Cases of successful pain control by switching from transdermal fentanyl to controlled-release oxycodone

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Introduction: Transdermal fentanyl (TF) is commonly used for pain control because it has fewer adverse effects, such as constipation, nausea, and sleepiness, compared with morphine. However, pain control with TF is difficult in some patients. But as shown below, we obtained a favorable response by switching to controlled-release oxycodone (CRO).
Case 1: A 41-year-old woman with recurrent uterine cervix carcinoma and severe pain in the lumbar region and lower extremities. A remarkable reduction of pain was obtained by switching from TF 4,800mcg/day to CRO 240mg/day (75% of the equianalgesic dose).
Case 2: A 54-year-old man with a primary tumor of unknown origin and multiple bone metastases. He had severe lumbar pain. A favorable pain control was obtained by switching from TF 6,000mcg/day to CRO 240mg/day (60% of the equianalgesic dose).
Case 3: A 62-year-old woman with pancreatic carcinoma and carcinomatous peritonitis. She complained of severe abdominal pain. A successful pain control was achieved by switching from TF (1,800mcg/day) to CRO 40mg/day (33% of the equianalgesic dose). There were also other cases in addition to these three cases. In all such cases, pain was associated with neuropathy, bone metastasis, or carcinomatous peritonitis.
Discussion and conclusion: Opioid rotation to CRO in patients who responded poorly to TF therapy led to successful pain control at doses lower than the equianalgesic dose. Opioids are often regarded as poorly effective against pain associated with neuropathy, bone metastasis, or carcinomatous peritonitis. However, in the present cases the efficacy of CRO differed from that of TF, indicating different mechanisms of action. Thus, patients for whom TF shows an insufficient analgesic

effect would not require a mere dose increase but an appropriate therapeutic strategy, including opioid rotation to CRO, according to the pathological condition of each patient.

PE 1.F305

Absolute bioavailability and transmucosal absorption of fentanyl from the BEMA delivery system

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Objectives: The objectives of this study were to analyze the absolute bioavailability of fentanyl from the BEMA delivery system (buccal soluble film), to determine the percentage of fentanyl dose that is absorbed through the buccal mucosa, as well as to compare the fentanyl plasma concentration profile following multiple BEMA Fentanyl units with an equivalent dose administered as a single unit.
Methods: Open-label, single-dose, 4-period, Latin-square, crossover study in 12 healthy volunteers. The study consisted of a screening visit and a 12-day inpatient treatment period in a Phase 1 unit. Each subject received 200 µg fentanyl citrate IV, 800 µg fentanyl citrate oral, 1 x 800 µg BEMA Fentanyl buccal, and 4 x 200 µg BEMA Fentanyl buccal, administered 72 hours apart. Subjects received naltrexone throughout the study period to block the respiratory depressive effects of fentanyl.
Results: Twelve subjects (6 males and 6 females) with a mean age of 27.3 years (range 19 to 37 years) were enrolled and treated. All 12 subjects completed the study. The study population was 50% Black, 33% Caucasian and 17% Hispanic.
The absolute bioavailability of fentanyl resulting from BEMA Fentanyl administration was 71%, compared to 35% after oral administration. Approximately 51% of the total fentanyl dose was absorbed through the buccal mucosa. There were no significant differences in the rate and extent of absorption following administration of an 800 µg dose as either a single dose unit or as multiple smaller dose units. No gender differences were seen in fentanyl exposure following BEMA Fentanyl administration. No SAEs or AEs leading to premature discontinuation were reported.
Conclusions: The BEMA system allows an efficient and highly reproducible delivery of fentanyl through the buccal mucosa. The overall safety profile of BEMA Fentanyl resulted similar to the known safety profile of fentanyl in other formulations.

PE 1.F306

Pain and fatigue: Do they really influence each other?

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Aim: Pain and fatigue are frequent in cancer and it is a common belief that they influence each other. The objective of this study is to analyse the comorbidity between pain and fatigue in women with breast cancer.
Methods: Cross-sectional study. Non-probabilistic sample composed of 182 women with breast cancer under ambulatory care, in any treatment or disease phase (means: age = 52.8 y; years of school = 12.4 y). Data were collected from July 2006 to March 2007. Fatigue was assessed by Revised Piper Fatigue Scale (0 to 10) and pain intensity by Numeric Scale (0-10). Fatigue and pain scores were classified in 0.1 to 4.9 = mild, and 5.0 to 10.0 = moderate or severe. Zero was not considered in the correlations. Statistical analyses were performed by Student´s t-test, Pearson´s correlation coefficient, and differences were considered significant when P<0.05.
Results: Fatigue was reported by 94 women (51.6%), from which 44 (24.1%) had moderate to severe fatigue (total score ≥ 5). Pain was reported by 86 women (47.2%), from which 50 (27.4%) had moderate to severe pain (total score ≥ 5). The comorbidity fatigue and pain happened in 20.8% of the sample and the correlation between fatigue and pain was 0.379 (P=0.003). The presence of pain increased fatigue (P=0.012), but the presence of fatigue did not influence pain (P=0.644).
Conclusion: Fatigue and pain were frequent in women with breast cancer, occurred in comorbidity and pain aggravated fatigue. Therefore, pain treatment can provide fatigue relief.
Study supported by The National Council for Scientific and Technological Development (CNPq) and The State of Sao Paulo Research Foundation (FAPESP).

PE 1.F307

Pharmacological differences of opioids regarding their efficacy against bone cancer pain

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Background and purpose: Opioids are the mainstay therapy for bone cancer pain management, but the clinical response varies widely. We examined the pharmacological differences of opioids through opioid rotation.
Methods: This was a prospective observational study. Four patients with bone pain who required opioid rotation to oxycodone because of inefficacy and/or adverse events were enrolled in this study between September 2006 and August 2007. They did not receive any cancer therapy within two weeks to reduce their pain. Their primary lesions were malignant lymphoma, malignant myeloma, colon cancer and liver cancer, and the primary sites of pain were the cranium, spinal compression fractures and iliac bone fracture. They were converted to controlled-release oxycodone from morphine or fentanyl. Pain intensity, safety profile and opioid daily dose at baseline and after opioid rotation were evaluated.
Results: Pain intensity markedly decreased after opioid rotation in all patients. Drowsiness and constipation were also improved after switching to oxycodone. The effective daily dose of oxycodone varied from 10 to 80 mg, which was about 25 to 40% lower than the general equianalgesic dose of the previous opioids. Besides, improvement of quality of life and an economic benefit were obtained.
Conclusions: These results suggest that oxycodone has a specific pharmacological profile compared to morphine and fentanyl. Further investigation is required to confirm the superior efficacy of oxycodone regarding bone cancer pain. Opioid receptor binding affinity, absorption and response to neuropathic elements may contribute to the differences in opioid efficacy. Opioid rotation is considered effective to improve refractory cancer pain, but the conversion dose should be carefully titrated based on opioids differences.

PE 1.F308

Effectiveness of continuous parenteral hydromorphone in advanced cancer patients failing on standard opioids

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Aim: In patients with severe cancer-related pain, continuous parenteral administration of opioids is often required. Hydromorphone (HM), compared to other opioids, has a higher analgesic potency. During the last years, in our clinic patients who failed on high doses of opioids were treated with parenteral HM. We performed a retrospective study in which the efficacy of parenteral HM was investigated among patients with advanced cancer and serious pain who failed to achieve adequate pain relief on opioids, other than parenteral HM.
Methods: Between December 2004 and December 2007, 44 patients, who were admitted to the acute palliative care unit, were treated with parenteral HM. Mean pain intensity at rest NRS (0-10) was daily assessed. The moment pain was adequately controlled (t1) was defined as the first day of at least 3 consecutive days during which HM yielded an average daily pain score of 4 or less and tolerable side effects.
Results: The reasons for rotation to parenteral HM (n=44) were inadequate pain control (n=10), severe opioid-related side effects (n=16), and reaching the maximum feasible volume of parenteral infusion of other opioids (n=18). Before switching to HM, the median daily oral morphine equivalent dose was 600 mg (range:80-1620 mg). At start the median daily dose of HM was 48 mg (range:12-216 mg). Adequate pain control was achieved in 36 patients (82%) within a mean of 6 days. Eleven of these patients still had side effects at t1, but they were scored as tolerable. The mean pain score at the start of HM treatment was 5.6 (sd=2) and at t1 2.6 (sd=1.6; p<0.0001). In this group the median dose of HM remained stable (48 mg). The median duration of successful parenteral use of HM among the 36 patients was 37 days (range:2-338), somewhat shorter than the median survival period of 61 days.
Conclusion: In patients with serious cancer pain, parenteral continuous administration of hydromorphone is an effective alternative without dose escalation.

PE 1.F309

Effectiveness and tolerance of transdermal fentanyl in oncologic pain

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Aim: Successful management of pain in the cancer patient requires careful assessment of the components of the pain complaint and accurate diagnosis of the cause of pain. Symptomatic management of pain involves pharmacotherapeutic strategies that focus on opioid use. Factors influencing the choice of opioid in patients with cancer pain include the severity of pain, response to previous analgesic therapy and available formulations. Long-term opioid prescription usually is condicionated by side effects. We present our service experience on starting and switching opioid treatment with transdermal fentanyl for cancer pain.
Methods: From February to September 2008 a total of 28 cancer patients who began pain treatment with trasndermal fentanyl (TF) were assessed. The effectiveness and tolerance of such treatment is prospectively evaluated.
Results: Prior to treatment with TF, of the 28 patients evaluated, 15 of them (53.6%) were being treated by the first analgesic step; 6 patients (21.4%) were being treated by the second step and 7 patients (25%) were being already treated by third step, but with a different drug from TF. 50% (14 patients) began treatment with TF at a dose of 25 mcg/h; 10.8% (3 patients) needed a higher dose than 50 mcg/h. A 43.2% (13 patients) related improvement of their pain (as measured by VAS scale) and 57.1% (16 patients) required a rising of dose of TF in the second follow-up visit. A 78.6% (22 patients) not mentioned any side effect which could deteriorate their quality of life. There were no severe side effects during the follow-up of patients.
Conclusion: TF is a safe third analgesic step treatment at the usual prescribed dose, either in patients who have previously used opioids or in those who do not. It is also an effective treatment for pain management in cancer patients with few side effects in short and medium term.

PE 1.F311

Use of methadone as a co-opioid in managing difficult pain: Review of 2 years of use within an inpatient hospice to explore its value

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Methadone as a co-opioid was introduced into our hospice practice in April 2005, with a supporting policy to guide as to when to initiate, how to initiate, and titration. Controlled drug records for inpatients from then on, to end March 2007 identified all patients using methadone (orally or subcutaneously) during their stay. Their notes were then analysed. Patient characteristics (age, diagnosis, pressing symptom) were noted; also drugs tried prior to initiation of methodone. Annotation re. initiation and titration was compared with recommended (policy) practice, and the effect of the addition of methadone was searched for both in descriptive text and by study of patients' drug charts. Notes were searched for any recording of toxicity or risk issues as a result of use.
758 inpatients were cared for in this time. 36 were initiated on methadone-in every case as a co-opiod. Not all benefitted but there was profound symptom improvement with low dose methadone in a few with very difficult pain who had tried multiple opioids and coanalgesics already. Some patients became toxic: some without benefit from methadone (thus stopped), but in two cases toxicity resolved with dramatic reduction in baseline opioid, without loss of comfort. Three drug errors occurred, in all cases for patients after discharge home. One stopped methadone, not realising it was a

key drug. One local pharmacy dispensed the wrong strength methadone concentrate, and one patient made a mistake with what dose to take regularly and what to take as needed for breakthrough pain.
Conclusion: Methadone as a co-opioid has been a valuable intervention for some of our patients with most difficult pain. The policy has required alteration to best support clinicians, pharmacists and patients in minimising risk of drug errors. Numbers involved were too few to be able to provide guidance on what future patient might benefit from this intervention but with some profound successes we continue with it.

PE 1.F312

Sublingual methadone for breakthrough cancer pain: A randomized clinical trial is not feasible but the treatment appears effective

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Background: Breakthrough cancer pain is prevalent and difficult to manage; episodes of pain can suddenly become severe, making it challenging to manage with slow-onset, strong opioids administered by mouth. An ideal breakthrough pain medication would be effective within a few minutes.
Methods: A multicentre, open label, feasibility study exploring sublingual methadone for cancer related breakthrough pain was undertaken. The primary objective was to demonstrate the feasibility of a novel clinical trial model in preparation for a definitive randomized trial. This model included screening, upward titration of methadone, and assessment of optimal dose, with each episode of pain treated as a separate data set. Secondary objectives were to demonstrate proof of analgesic concept, with targets of half of patients obtaining meaningful pain reduction within 5 minutes and ≥60% of individual breakthrough episodes successfully treated within 30 minutes. Meaningful pain reduction was defined as a ≥2 point or≥30% reduction of pain.
Results: Over 2 years, approximately 1800 patients were screened for inclusion from three sites across Canada; 9 patients entered the trial, 5 reached optimal dose and 85 individual episodes of breakthrough pain were evaluable up to 60 minutes post treatment. Two of 5 patients demonstrated clinically significant pain relief in the majority of episodes by 5 minutes with one additional responder by 10 minutes. Toxicity was uncommon and usually mild. We are developing a predictive model for the optimal number of breakthrough episodes to measure per patient.
Conclusions: Based on the results of this feasibility study a larger randomized clinical trial using this research model would not be successful. However, extensive information obtained from small numbers of carefully studied patients gives preliminary evidence to suggest that sublingual methadone is rapidly absorbed, effective, safe, and well tolerated.
Funding: CIHR, Alberta Cancer Board.

PE 1.F313

Safety and efficacy of hydromorphone OROS® in the treatment of moderate-severe pain in opioid naïve cancer patients. Preliminary results of an open prospective phase II study

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Hydromorphone (H) hydrochloride is a μ-opioid agonist: the novel, once-daily, extended-release (ER) hydromorphone formulation utilizes the OROS® Push Pull TM osmotic active technology designed to release hydromorphone at a controlled rate for up to 24 hours. The aims of this open prospective phase II study were to verify the efficacy, safety and impact on quality of life (QoL) of the treatment with H OROS® in moderate to severe pain of opioid naïve cancer patients. Four visits (V) were planned for the the study: V1 before treatment with H OROS®; V2 24 h after treatment; V3 and V4 after 7 and 14 days, respectively. Pain intensity (acute and chronic) was assessed from V1-V4 using a numerical rating scale (NRS), toxicity was assessed from V1-V4 using the NCI CTC v3 criteria, and QoL was evaluated at V1 and V4 using Brief Pain Inventory (BPI) questionnaire. For each daily activities considered by BPI the score was from 0 (no interference) to 10 (complete interference). From May to October 2008 (the study is still ongoing) 13 patients were enrolled (M/F 3/10; mean age 65.1) and 11 patients completed the study. The mean decrease in pain from V1 to V2 was 3.7 NRS (from 7.9 of V1 to 4.2 of V2) ($p<0.001$). The decrease observed between V1 and V3 and V4 was similar to that between V1 and V2 ($p=0.000$ and $p=0.000$, respectively). At V1 the interference of pain involved all the daily activities considered by BPI. At V4 the interference of pain was reduced achieving a statistically significance only for "sleep" ($p=0.017$) and "walking capacity" ($p= 0.022$). The treatment was safe: only grade 1-2 toxicities were observed with a peak of 45.4% for both mouth dryness and somnolence and 36.4% for constipation.
Conclusion: H OROS® was effective in improving moderate-severe pain in a selected population of opioid naïve cancer patient, safe and able to reduce the interference of pain on QoL.

PE 1.F314

Continuous intrathecal infusion for intractable cancer pain

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Even using cancer pain management according to World Health Organization methods, pain can be difficult to control in some patients, such as those with recurrent intrapelvic cancers. We retrospectively evaluated the effectiveness of continuous intrathecal infusion of morphine with local anesthetics in 20 patients, along with histopathological changes in spinal cord after intrathecal infusion in 5 cases.
Cases and methods: Subjects comprised 20 patients (10 men, 10 women; mean age, 59.0 years). Primary disease was rectum (n=6), nephroureter and prostate (n=3 each), cervical and breast (n=2 each) and others (n=4). All patients reported severe pain in the buttocks to lower extremities.
In 9 cases, a polyurethane epidural catheter was inserted subarachinoidally and an access port was implanted subcutaneously. In 11 cases, a polyamide resin epidural catheter was used and a subcutaneous tunnel about 30 cm long was made. Initial daily morphine dose was 1/100 of the daily oral morphine-equivalent dose. Bupivacaine or ropivacaine was used, but now only bupivacaine was used at 5 mg/day starting dose. Drugs were diluted in normal saline, with a total volume of 12 ml and an infusion speed of 0.5 ml/h.
Results: Mean starting morphine dose was 4.7 mg and final was 11.6 mg. Mean starting bupivacaine dose was 12.9 mg and final was 28.9 mg. Mean duration of administration was 77.1 days. Fourteen patients whose pain was controlled to <4 on a 0-10 scale were considered to have achieved good control. In 2 of the 5 patients examined, histopathological changes such as gliosis were observed in the spinal cord.
Discussion and conclusion: Continuous inthrathecal infusion with morphine and local anesthetics appears useful and safe for intractable cancer pain. However, this method carries a risk of possible damage to the spinal cord. Given the small sample size in this study, further examination is needed.

PE 1.F315

Optimization of pharmacotherapy of pain in palliative medicine

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Introduction: Pain is one of the most common disorders complained about by palliative patients. The basic method of treating pain is pharmacotherapy. One of the most frequently used analgesics are nonsteroidal anti-inflammatory drugs (NSAID), whose application in case of palliative patients is encumbered with a significant risk of adverse effects and interaction with other, simultaneously administered drugs.
Patients and methods: The analysis pertained to 76 reports on post-medication adverse effects with palliative patients which were received by the University Centre for Adverse Drug Reactions Monitoring and Investigation in Krakow between 01st January, 2007 and 31st December, 2007, which were related to the administration of analgesics. In 36 cases (47,4%) the adverse effects appeared as a result of administering one analgesic; in as many as 24 cases (31,5%) patient at the same time applied 2 NSAIDs, what has to be considered as a pharmacological error, however in 16 cases (21,1%) the adverse effects appeared as the subsequence of unwanted interaction among drugs administered simultaneously.
Results: In all 76 cases the analgesics treatment was modified taking into consideration the existing risk factors of appearance of post-medication adverse effects. It has to be noted that in as many as 52 cases (68,4%) prior to the analgesic treatment the risk factors of appearance of adverse effects were known, which had not been taken into consideration in planning pharmacotherapy of pain. It has to be added that 48 cases (63,2%) of adverse effects which occurred in pharmacotherapy of pain have been qualified as severe and they required treatment in ambulatories and hospitals.
Conclusion: Individualization and optimization of pharmacotherapy of pain at palliative patients enables us to increase the effectiveness and safety of administered treatment and to decrease a risk of adverse interactions of medicines in polytherapy.

PE 1.F316

The cancer pain syndromes associated with refractory pain required high dose opioid use or multiple drug therapy

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Aim: It may be difficult to assess whether to give a higher dose of opioid or yet another adjuvant analgesic, when titrating adequate analgesic doses in the patients with refractory cancer pain. The aim of this study was to clarify the characteristics of the patient groups with cancer pain which required high dose opioid use (HDO) or very multiple drug therapy (vMDT) in order to resolve this problem.
Methods: We retrospectively studied the medical records of all hospitalized cancer patients supported by palliative care teams for over two weeks between April 2004 and August 2008. Information was collected regarding age, sex, tumor type, cancer pain syndrome, concomitantly administered analgesics and adjuvant analgesics, and maximum opioid dosage. We assessed the pain syndromes associated with patients required HDO (>599mg/day of oral morphine equivalent) or vMDT (more than 5 drugs), respectively. The date was statistically analyzed with logistic regression analysis.
Results: 246 patients were identified. The maximum opioid dosage was 120mg/day (median, range 0-1440mg/day), and 21 patients (8.5%) were given HDO. 3.0±1.2 analgesics and adjuvant analgesics were administered concomitantly (mean ± SD), and 29

patients (11.8%) required vMDT. Bone pain (OR: 3.28, CI: 1.06-10.09) was independently associated with HDO, and neuropathic pains involving the peripheral nervous system (odds ratio[OR]: 7.46, 95% confidence intervals[CI]: 2.66-20.91) and neuropathic pains involving the central nervous system (OR: 4.77, CI: 1.15-19.81) were associated with vMDT, respectively.
Conclusions: These results might indicate that adjuvant analgesics are likely needed to combine aggressively in the presence of neuropathic pain and opioid dosages should be increased in the presence of bone pain when treating intractable cancer pain.

PE 1.F317

Bowel function during a pain therapy with a combination of oxycodone / naloxone prolonged-release tablets in geriatric patients

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Aims: Physical pain is one of the most frequently experienced symptoms of patients. A therapy with WHO-step III opioids is often necessary already at the start of pain therapy in order to achieve sufficient symptom control. Constipation is one of the most frequent and persistent side effects of opioid therapy, and it is feared by many patients as much as the symptom of pain. The aim of the study was to evaluate whether geriatric patients with severe to most severe pain will benefit from the treatment with oxycodone/naloxone prolonged release tablets (OXN), particularly with regard to constipation and global patient satisfaction.
Methods: We evaluated in this exploratory, non-randomized, open-label, monocenter study the bowel function in geriatric patients treated with OXN. During the treatment phase patients were titrated up to an adequate pain control with a maximum total daily dose of 40/20 mg OXN. The Bristol Stool Form Scale (BSFS) (Type 1-7) and Bowel Function Index (BFI) (0-100) were used to asses the consistency and frequency of their bowel movements throughout the study. Global patients satisfaction was assessed with Patient Global Impression of Change Scale (PGIC) (1-7). Statistics: mean±SD, significance $p < 0.05$.
Results: 12 patients were included; 5 of the patients (41.7%) were male. Mean age was 76.0±12.0 y. Length of stay was 18.8±4.7 days. At admission all patients reported to suffer from opioid-induced constipation. Daily mean dose of OXN was 28.3±9.4 mg. BFI improved significantly in all patients (75.0±24.3 vs. 42.1±21.3) (p=0.002); BSFS changed in mean from type 1.8±0.6 to 4.4±0.7 (p=0.002). PGIC in mean at discharge was 1.4±0.5.
Conclusions: All study results showed a clinically relevant improvement in bowel function under treatment with OXN. PGIC showed increased satisfaction.

PE 1.F318

Effect of hydromorphone injectable solution on ventilation during the titration phase for cancer pain therapy

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Aims: Hydromorphone (HM) is a widely used semi-synthetic opioid that has become an increasingly important option in the treatment of severe chronic cancer pain. We investigated the use of hydromorphone and its effect on ventilation during the titration phase in patients with cancer pain.
Methods: 32 patients admitted to our PCU were included in this prospective, non-randomised trial. At admission, all patients suffered from sever cancer pain. All patients were titrated up to an adequate pain control with hydromorphone injectable solution (subcutaneous application). The initial opioid dose was defined according to pain intensity as well as with regard to patients´ performance status and with consideration whether patients were opioid-naïve or pre-treated with strong opioids. Titration steps were: 0.5-1-1.5 2-2.5-3 mg etc.). TcpaCO2, SaO2 and PF were measured transcutaneously by means of a SenTec Digital Monitor (SenTec AG, Switzerland). Statistics: mean±SD; Wilcoxon Test, significance $p < 0.05$.
Results: As early as 30 min after the first hydromorphone application a significant improvement was shown in the intensity of pain, mean respiratory rate decreased from 28.0±4.9 / min to 22.2±4.2); after 120 min to 21.0±3.1 /min, (P = 0.001) breaths/min. There was no significant increase in tcpaCO2 30 and 120 min after opioid application (37.4±3.1 mmHg vs. 36.6±3.5 mmHg after 30 min (p=0.382) and 36.4±3.0 mmHg after 120 min (p=0.345)). SaO2 did not change significantly (p=0.096).
Conclusions: In conclusion we found that there is no higher risk for respiratory depression and no change in paCO2-levels in patients titrated up to an adequate pain control with hydromorphone injectable solution. The first hydromorphone application, however, resulted in a significant decrease in the intensity of pain and in respiratory rate.

PE 1.F319

Safety of hydromorphone in the management of intractable cancer pain in palliative care patients with severe renal failure

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Aims: Patients with advanced cancer frequently experience intractable pain and suffer from renal failure. In cancer pain management the renal function influencing the safety of opioid therapy is of special interest. Accumulation of active metabolites of opioids explains cases of opioid toxicity in patients with decreased renal function. We reviewed the experience and safety of the use of Hydromorphone (HM) in palliative care patients with a severe renal impairment.
Methods: A retrospective study of 443 patients admitted to our palliative care unit in 2006 to 2007 was performed. Patients with severe renal failure (creatinine serum concentration ≥5.0 mg/dl) and intractable cancer pain treated with hydromorphone during their hospital stay were included. Statistics: mean±SD, significance $p < 0.05$.
Results: Severe renal impairment was documented in 49 (11.1%) patients, (age 68.5±13.1, 26 (53.1%) men). In all patients, the reason for admission was inadequate control of pain, and in 85 patients additional manifestation of opioid toxicity. All patients had cancer in an advanced stage. Mean Karnofsky index was 40 (range 20-50). Mean serum creatinine concentration was 8.2±2.50 mg/dl, and blood urea nitrogen 181.0.0±142.3 mg/dl. Of the 90 patients 5 were opioid-naïve. Mean daily dose of HM at discharge was 49.0±40.0 mg (368.0±300.0 mg morphine equivalence - considering an equianalgesic conversion ratio of M:HM = 7,5:1). Nausea, myoclonus and sedation were significantly reduced by use of HM. Analgesic response improved clearly.
Conclusions: Symptoms of opioid toxicity can be relieved by opioid switching to HM in patients with severe renal failure. Prospective studies with thorough documentation of the symptoms of opioid toxicity in patients with renal failure are needed to confirm our results.

PE 1.F320

Breakthrough Pain (BTP): A study in advanced and far advanced onocological patients assisted at home by ANT Italia Foundation

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Objective: Evaluation of Breakthrough Pain (BTP) in oncological Patients assisted at home.
Patients and methods: From January 1st 2007 to April 30th 2008 a total of 72 advanced and far advanced oncological Patients have been assisted (life expectancy: range from 1 to 4 months).
Eligibility criteria:
- Life expectancy higher than 1 month
- Presence of basic chronic pain in therapy with opioids
- Basic pain controlled in the last 3 days (administration of a pain flow sheet NRS) for evaluation of BTP
- Undamaged consciousness state.

Results: Out of 72 Patients, 47 were evaluable.
Out of 47 Patients observed, 17 (36.2%) presented basic chronic pain.
In 30 Patients (63.8%) with basic pain presented also BTP events. Of these it has been possible to evaluate the clinical characteristics and the therapeutic approach.
Our results: 53.3% mixed pain; 85% BTP due to cancer; 33.3% BTP due to the limbs, 26.1% to rachis; less than 5 episodes/die of BTP in 88.3% (median daily of 2.33; duration of BTP: less than 30 minutes in 76.6% of cases; intensity: in 90% of cases NRS 7-10).
Treatment: 77% of the Patients treated with fentanil citrate oral transmucosal.
Conclusions: In literature some studies show a prevalence (63, 8 %) of BTP similar to that found out in our study, also some data on clinical and temporal characteristics of this phenomenon, with some little exception: no case of so called BTP "end of dose", a new kind of BTP was evaluated that we have defined "idiopathic-incident pain or mixed pain". Evidenced a percentage 53.3% of mixed pain physiopatological.
It is confirmed that it is necessary and advisable to use fentanil citrate oral transmucosal, i.e. a easy-to-use and indicated drug for this kind of pain.

PE 1.F321

Topical Pain Medications (TPM) for patients with advanced cancer

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Introduction: Patients (pts) with advanced cancer may suffer from a variety of pain syndromes (PS), including those caused directly by the disease or by therapeutic interventions (surgery, radiation, or pharmacotherapy). These pts often have more than one type of PS (neuropathic pain is often the main complaint), require several medications to obtain benefit, and as such, are at increased risk for drug induced adverse effects. The use of medications applied topically to treat specific PS may have several beneficial effects, such as concentrated treatment to a specific area or site, avoidance of the hepatic first-pass effect, no possibility of drug interactions, and little or no systemic side effects.
Methods: A retrospective review was conducted at our institution to identify all pts treated with TPM for relief of PS, either due to adverse effects or poor effect of other drugs or pts preference, between 06/06 and 10/08.
Results: A total of 30 pts (13 males) used TPM; we have complete data on 26 pts thus far. Nineteen pts stated they found improvement in their PS (measured by VAS), 5 had no benefit, and pain worsened in 2 pts. Several cancers were represented, including colorectal(8), breast(6), genitourinary(6), hematologic(4), as well as mix of others(6). A variety of PS were treated, including neuropathic pain due to disease (14), neuropathies due to previous cancer therapy (14), and pain unrelated to the cancer (2). The most common medications used were ketamine and lidocaine (n=30), in combination with gabapentin, ketoprofen and baclofen, all of which target different receptors involved in PS. These were delivered through either PLO or Lipoderm gel formulations. No patient discontinued the medications due to adverse effects.
Conclusions: Topical administration of pain medications is beneficial against PS, especially neuropathic pain, and is well tolerated by patients with advanced cancer.

PE 1.F322

Experience of methadone therapy in 35 consecutive chronic malignant pain patients

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Introduction: Methadone is an opioid agonist considered a second choice drug in the management of cancer pain when compared to the use of morphine. Its plasmic half-life, the possible pharmaceutical interactions and the complexity of its receptor action make this drug particularly effective when treating cancer pain but managing this drug can also be complex, mainly due to the risk of accumulation in the body.
Objective: The objective of the study was to describe the experience of methadone use in 35 consecutive chronic pain patients managed in a single palliative care center.
Design, setting, patients: A retrospective study has been carried out concerning patients suffering from cancer pain treated with methadone, while receiving care in a Hospice or directly at home by our palliative care service, starting from January 2007. Outcome Measure. Effects on pain relief and function, conversion ratio from other opioids, side effects, and disposition were reviewed.
Conclusion: From our experience, methadone is an effective alternative to conventional opioids for chronic malignant pain management when used by experienced clinicians.

PE 1.F323

Inconsistent opioid prescribing guidelines

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Background: One of palliative medicine's key messages over the past 30 years has been to encourage safe and effective opioid prescribing. This has been achieved by education, explanation and reassurance of both patients and prescribers and by using tools such as the WHO analgesic pain ladder. However, current advice on guidance of starting and titrating opioids can appear to be inconsistent when taken at face value.
Aim: To evaluate the differences in current prescribing guidance for opioids and to provide consistent guidance about opioid prescribing with, as a minimum requirement, advice on starting doses, median doses and on titration.
Methods: We review fourteen commonly sought sources on opioid prescribing for physicians and highlight discrepancies and differences and present the results.
Results:
- Some sources make little or no mention of starting doses, titration advice or advice on upper limits.
- Starting doses for opioid-naïve patients vary from 6 - 60mg per 24 hours.
- Titration advice varies from 30% every 2-3 days to a 50% increases four hours after the previous dose.
- Upper limits for oral morphine vary from 300mg/24hours, through 3000mg/24hours, to statements that there was no maximum dose.
- It is unusual to find median doses mentioned.
Conclusion: We suggest that a similar review of advice on commencing and maintaining opioid medicines in other countries may yield similar discrepancies and that solid, international consensus is currently lacking, but is likely to be addressed by the EAPC in the near future. Until then, we suggest a strategy wherein guidelines should provide consistent guidance about opioid prescribing with, as a minimum requirement, advice on starting doses, median doses and on titration. We present a format to this effect in the form of a table.

PE 1.F324

Efficacy of titrated doses of intranasal fentanyl spray (INFS) for breakthrough cancer pain: Results of a double-blind, placebo-controlled, crossover confirmatory trial

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Aim: To confirm the efficacy of intranasal fentanyl spray (INFS), for the treatment of breakthrough pain (BTP) in patients with cancer, and to establish its long-term safety.
Methods: This was a randomised, double-blind, placebo-controlled, crossover, multicentre trial using INFS titrated to doses of 50, 100, and 200 ?g to treat episodes of BTP in cancer patients receiving chronic opioid treatment and experiencing ≥3 BTP episodes/week and ≤4 /day. Patients were titrated to a successful INFS dose which they then received in a randomised, double blinded sequence, for 6 of 8 BTP episodes (≤4 per day), and placebo for 1 BTP episode each of episodes 1-4 and 5-8, respectively. The primary efficacy endpoint was pain intensity difference at 10 min (PID10) post dosing. The intention-to-treat (ITT) population was composed of all randomised patients who received at least one dose of double-blinded study medication.
Results: In 120 enrolled patients, 113 were randomised and 111 constituted the ITT set, with n = 17, 51, 44 titrated to 50, 100, 200µg, respectively. The LS mean PID10, was significantly higher for treatment with INFS vs placebo (1.26, $p < 0.001$, ITT), as was LS mean INFS sum of pain intensity difference up to 60 min (SPID0 - 60) score (1.7, $p < 0.001$), and LS mean general impression (GI) score at 60 min (0.93, $p < 0.001$). The mean overall responder rate with INFS was more than double that of placebo (51% vs 21%, respectively). Few adverse events (AEs) were recorded: 4 patients (3.6%) had nausea, 2 (1.8%) had vertigo, and 2 (1.8%) experienced progression of underlying malignancy.
Conclusions: In opioid-tolerant cancer patients, INFS titrated to doses of 50, 100 and 200 µg demonstrated significant and fast onset of pain relief at 10 minutes post dosing showing BTP was effectively relieved. INFS at all doses was well tolerated. INFS constitutes a new treatment option in BTP.

PE 1.F325

A joint approach to interventional pain management for cancer pain

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My colleague Manohar Sharma and I would be keen to offer an interventional pain workshop at the EAPC conference.
We run a joint cancer pain clinic between the pain service at the Walton Centre for Neurology and Neurosurgery and Aintree Specialist Palliative Care Services in Liverpool U.K. A wide range of procedures including neuroaxial infusions, IDDS, Cordotomy, intrathecal neurolysis and coeliax plexus blockade are offered through this service. We are a tertiary referral centre for these procedures and see patients from within the U.K. We practice and are particularly keen to advocate a joint approach between pain and palliative care specialists in assessing these patients.
We would like to run a case based workshop, approximately 60min long with maybe up to forty participants. Key procedures such as percutaneous cordotomy and neuraxial infusions would be covered. We have recently run such a workshop for a national training day of palliative care trainees (Doyle Club study day) which evaluated highly.

PE 1.F326

Withdrawn

PE 1.F327

Use of invasive analgesic techniques for pain control in an acute palliative care unit: Preliminary results

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Introduction: Around 80% of patients suffering from cancer pain (CP) obtain good analgesia if they follow the WHO analgesic ladder. The rest of the patients with CP may require invasive analgesic techniques (IAT), either due to secondary effects or to the poor effect opioids. Our unit has recently started a "joint-venture" with the Pain Clinic to comprehensively care patients with complex CP syndromes, including their diagnosis and treatment. These preliminary results reflect a cooperative work carried out on CP relief. Period Feb-May 08.
Aim: To describe those patients who required an IAT and the overall analgesic results obtained.
Material & methodology: Patients who required an IAT (spinal infusion, nervous blockage and anesthetic infiltration). Demographic variables, pain syndromes (PS), type of IAT, complications derived from the technique, analgesic efficacy and subjective perception of the patient were registered.
Results: 13 patients were included. Mean age was 63.7 years and 76.9% were men. A total of 21 IAT were performed. Five patients required more than one technique to control their pain. The 3 most frequent tumors were lung, prostate and rectum. The median PPS was 60. The medium daily dose of oral morphine equivalent required before the IAT was 213.5mg and ≥ 1 opioids rotations had been done to more than half of the patients. The most frequent PS was pelvis pain (23.1%), the most used IAT was the spinal infusion (28.6%). The analgesic improvement was fast and had statistical signification. Half of the patients perceived a significant CP improvement. AE from the IAT were not observed. Most complications were of technical origin (catheter migration, disconnection or dysfunction).
Conclusions: Pelvic pain was the PS most frequently requiring an IAT and the most frequently used technique was the spinal infusion of analgesics. The use of the IAT offered a very significant and fast improvement of CP. Patients referred having good control of their symptoms.

PE 1.F328

Pain treatment with sustained-release (SR) hydromorphone in patients with prostate tumour

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Aim: To evaluate efficacy, safety and controllability of pain therapy with SR hydromorphone in tumour patients with a focus on patients with prostate tumours.
Methods: Multi centre non interventional study with 2041 patients (∅ age 66.1 ± 11.2 years) with severe, progressive pain. Analysis of a subgroup with prostate cancer. Patients received primarily twice daily SR hydromorphone in pain adapted doses after an initial examination. Follow-up was to be performed after day 3 and 7 with a final examination after about 21 days. Pain intensity was to be measured using a numeric rating scale (NRS 0=no pain to 10=strongest conceivable pain). Quality of life was to be specified by the patient and to be documented in a self-evaluation questionnaire based on the parameters of general activity, mood, walking ability, work, social contacts, sleep and vitality (total score: 0=no impairment to 70=most severe impairment). At the end of the observational study physicians assessed efficacy, tolerability and compliance.
Results: Average pain intensity in patients with prostate cancer (N=287) was reduced significantly compared to start of therapy with SR hydromorphone from NRS 6.2±1.6 to 2.7±1.4. The individually titrated dose of hydromorphone increased during the treatment phase of about 3 weeks from ∅13.4 to 21.0 mg/d. With hydromorphone the rate of patients suffering from typical opioid symptoms was low. Quality of life parameters improved significantly during therapy. Both efficacy and tolerability as well as patient compliance were rated as ?very good" and "good" by the doctors in over 92% of cases.
Conclusion: SR hydromorphone is safe, effective and well controllably in patients with progressive tumour pain - especially determined in patients with prostate cancer very often associated with painful bone metastases. Quality of life increased significantly.
Acknowledgement: Supported by grants from Mundipharma GmbH, Germany.

PE 1.F329

The use of cannabinoids (CBs) for the treatment of chemotherapy-induced peripheral neuropathy (CIPN): A retrospective review

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Background: CIPN is a common toxicity associated with the use of chemotherapy (CT) agents such as platinums, taxanes and vinca alkaloids. Patients (pts) may suffer from pain that adversely affects their quality of life, regardless of their disease trajectory. Preclinical research has shown CBs to be effective in preventing CIPN. CBs can be beneficial for cancer pain, although their specific benefit in pts with CIPN remains unknown.
Methods: A retrospective chart review was conducted to identify all pts with CIPN treated with CBs at our institution between 7/07-10/08.
Results: Eight pts were identified; 6 were male. Six pts had received platinum-based CT. Four had colon cancer. Four pts had metastatic disease. The median time to CIPN treatment (post-chemotherapy) was 4 months (0-84 months). All pts had 2+ neuropathy based on the NCI-CTC for Adverse Events. Pain improved in 7/8 pts with CB treatment. In those who responded, the improvement was as much as 7 points on an 11 point VAS. Two pts who transiently stopped treatment noted increased CIPN symptoms. Three pts eventually stopped treatment (1 due to side effects).
Conclusions: Treatment with CBs appears to benefit some pts with CIPN. Further research is needed to explore the optimal use of CBs in pts with CIPN.

PE 1.F330

Opioid use in palliative home care: Results from an eight year study

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Objective: To determine and analyze opioid use and its cost in the region of Navarre and what has been its evolution over the past nine years.
Methods: A retrospective observational study of all prescriptions made in the health system subgroup N02A (narcotic painkillers) in the province of Navarra during the period 2000-2008. The data are obtained through the process of billing for prescripted drugs of Navarra. These data are treated with a computer program that allows analysis of aggregate consumption by active ingredients.
It has been used the number of Defined Daily Dose (DDD) already consumed. After that, it has been estimated the number of defined daily doses per 1000 inhabitants daily (DDD/1000/día=DHD). We analyzed the 4 major opioides.
Results: Opioid consumption in Navarra has been multiplied by 5.17 between 2000 and 2007. It has gone from 0,292 to 1,511 DHD. The active substance most commonly consumed in 2007 was the transdermal fentanyl (1,039 DHD) followed by morphine (0,125 DHD). With regard to developments in these 8 years, the use of transdermal fentanyl has increased by 7 and two drugs have strongly emerged: oxycodone since 2004 and buprenorphine transdermal since 2002, which constituted in 2007 up to 23% of total strong opioid used.
The use of parenteral morphine has increased threefold since 2005.
The total expenditure of opioids in euros in 2006 amounted to 1.559.456 euros We will present dates of 2008 in the congress.
Conclusions: Opioid use in the extrahospital environment of Navarra has multiplied sevenfold in the past eight years.
The emergence of new drugs (transdermal buprenorphine and oxycodone) has contributed significantly to this increase.
Despite the overall increase, there has been no increase in the use of morphine, so their use should be strengthened.
DHD parenteral morphine has been multiplied by three over the last three years, coinciding with the creation of the Home Care Team.

PE 1.F331

Significant pain relief with intravenous ibandronate in symptomatic bone metastases

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Aim: Pain in bone metastases is usually diffuse and a selective treatment is therefore hard to find. Recent publications 1,2,3 drew attention to the analgesic effect of loading dose of ibandronate (BONDRONAT).
Methods: Patients with painful bone metastases requiring analgesics, were treated with loading dose bondronat (4mg/day on three subsequent days). VAS score and analgesic consumption were evaluated.
24 patients were treated from 1/2005 to 10/2008. All patients had diffuse bone metastases and severe pain (VAS > 5);initially even resistant to strong opioids. Median age 76 (range 50-86). Tumor types: prostate 5, lymphoma 2,myeloma 5, breast 5, lung 6, colon 2. VAS evaluation was done prior to bisphosphonate administration and on day 4 (24 hours after the last administration).
Results: Median VAS dropped from 8/10 to 3/10 after administration of BONDRONATE. This effect was seen across tumor types, and also in sites of prior irradiation. There were no side effects noted, nor subsequent renal function deterioration
Conclusion: In symptomatic bone metastases with significant pain, refractory to standard analgesics and radiotherapy, loading dose ibandronate represents a simple and non toxic treatment to obtain significant pain relief in a very short time.
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PE 1.F332

Feasibility study of brief patient based educational DVD for cancer pain

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Aim: To assess feasibility of randomised, controlled phase III clinical trial evaluating brief DVD-based educational intervention for cancer pain in palliative care patients. Recent meta-analysis has shown benefit of education when given as intensive nurse coaching but brief interventions have not been assessed.
Methods: Single centre longitudinal observational design. Patients with cancer pain living at home and their carers were recruited from hospices and oncology outpatients. Participating dyads were shown DVD at baseline and given a DVD and leaflet to take home. Dyads were shown DVD again at 7 days and 30 days later. Educational DVD was 6 minutes in duration and addressed pain assessment, compliance aids and common fears about painkillers. Patient and carer outcomes assessed before the intervention and at each follow up included pain intensity, pain interference, knowledge and attitudes towards pain management and medications, and psychological and self-efficacy measures. Outcome measures were analysed using linear mixed effects modelling. Acceptability of DVD format, satisfaction with information, recruitment and attrition rates were also evaluated.
Results: 15 patients and 10 carers were recruited; 3 patients withdrew before second visit, and 2 withdrew before final visit due to deteriorating health. Patient outcomes: mean worst pain intensity fell from 6.2 to 5.3 at 30 days (p=0.06); mean knowledge and attitudes scores improved from 64 to 76 (p=0.014). Patients and carers found DVD format acceptable and content helpful.
Conclusion: Findings suggest that brief educational interventions are practical and potentially effective within 30 day follow up period. Multicentre randomised controlled clinical is now needed (based on sample size calculation from this data) to evaluate this intervention further in palliative care population.
Funding: NAPP Educational Foundation UK.

PE 1.F333

Symptom clusters in advanced cancer: Role of systemic inflammation

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Aims: Cancer symptoms rarely exist in isolation and in recent years the concept of symptom clusters has been increasingly discussed in the literature. Systemic inflammation has been suggested as a possible underlying mechanism of cancer symptom clusters. This study examines whether pain, depression and fatigue exist as a symptom cluster. The relationship of C-reactive protein (CRP- as a measure of pro-inflammatory cytokine activity) to pain, depression and fatigue is examined and a possible biological explanation of these cancer symptoms is explored.
Methods: Analysis was undertaken of two large cancer trials (n=718). Symptoms were assessed using the European Organisation for Research and Treatment of Cancer (EORTC) Quality of Life Questionnaire C-30. Measurement of plasma CRP was performed. Multivariate analysis was undertaken and Pearson correlation coefficients were calculated between all pairs of variables. A series of regression analyses were run relating pain, depression, fatigue and CRP.
Results: Pain, fatigue and emotional functioning (mood/depression) were strongly related (correlation significant at the 0.01 level - 2 tailed). CRP was related to pain and fatigue (to levels of statistical significance, p<0.05). CRP was positively correlated with emotional functioning but this did not reach levels of statistical significance.
Conclusions: In this dataset, there are strong associations between pain, fatigue and depression. This apparent symptom cluster has a statistical relationship with plasma CRP. While we cannot conclude a definite causal relationship between systemic inflammation (using CRP as a biomarker) and this cluster of symptoms, these results give a strong indication that further elaboration of this concept could be of great clinical interest as well as moving the research agenda forward.

PE 1.F334

Pain control: Nurses and patients view

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The purpose of this research: To examine the properties of the patient's pain control in the district hospital.
Research was done in in the hospital of Gargzdai city, Klaipeda municipality, 2008 Spring.
The method of research: Anonymous, questionnaire inquest. Two questionnaires were intended: one was assigned for the patients of pain (30 patients participated), other for general practices nurses (30 nurses participated in the research), trying to ascertain the properties of the patient's pain control in the hospital. After explaining the purpose of research, relevance, substantiality, questionnaires were distributed. Questionnaires were created by the authors.
Results: 67 percent of nurses thought, that the pain most rightly can be described by the pain patient himself, 40 percent of patients thought that nurses can evaluate pain better then patients themselves (p<0,05). Pain patients were not motivated to suffer pain for longer time. The patients suffered pain for longer time, because they were afraid to dose up of drugs (60 percent of nurses and 40 percent of patients). 67 percent of nurses and 70 percent of patients thought, that after treatment the pain will disappear. Patients suffered from chronic pain and they believed that pain will be treated well. Analysis of assessment of pain intensity, use of pain killers and acceptability and effectiveness of pain method differ statistically. Nurses (73 percent) chose injections as the best method of pain control, but for most of patients (90 percent) it is the most unacceptable.
Conclusion: Patients are not independent in assessment of pain intensity and pain control.

PE 1.F335

Transdermal fentanyl in cancer pain patients

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Certain number of cancer patients (pts) unnecessary suffer due to inadequate pain control. We evaluate efficiency and tolerability of transdermal fentanyl (TF), which is recently available in our country, for treatment of patients with severe cancer pain.
From January 2007 until January 2008, 165 cancer pts were treated with TF. Out of that were 89 (54%) men and 76 (46%) women. Previously, the most of them had therapy with NSAID or mild opioides with/without coanalgetics. All types of cancer pain (nociceptive, neuropathic, and mixed) were observed. In pts with breakthrough pain additional parenteral analgetics (tramadol or morphine) were applied.
Distribution due to primary tumor site was: 40/165 (24%) breast cancer, 34/165 (21%) lung cancer, malignant GIT tumors 22/165 (13%), pancreatic cancer 13/165 (8%), head and neck cancer 13/165 (8%), other tumor types 43/165 (26%). TF was introduced in pts with pain intensity 7 of VAS. For most of the pts initial dose was 25mcg//h. During course of disease 136 (82, 4%) patients were treated with doses 50 to 100mcg/h. Doses above 100mcg/h were applied in 29 (17,6 %) patients. Out of those, one patient was treated with 200mcg/h, which was maximal applied dose. In the whole group of pts serious adverse effects have not been reported.
Our patients were treated with TF too late (pain intensity 7 of VAS). Introduction of TF could be earlier in course disease, due to its efficiency and good tolerability.

PE 1.F336

Minimally invasive procedures in cancer pain treatment

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Introduction: It has been argued the employment and executing time of minimally invasive procedures (MIP) in strategy of cancer pain treatment. Many place MIP as the IV step of analgesic ladder, others use blocks

from the beginning of therapy. We treat MIP as adjuvant therapy and use them according to diagnose on each step of analgesic ladder.
Aim: Assessment of efficacy of MIP in patients, treated in our Department (D) during first 3 months of 2008.
Material and method: 50 (50% of all admitted to D) patients treated by MIP. All reported pain in NRS > 4.
Procedures performed:
Neurolytic blocks of celiac plexus - 9 patients, superior hypogastric - 8, ganglion impair -5; Thermolesions: suprascapular - 2, intercostal - 1, dorsal roots or facet joints: lumbar - 7, thoracic - 1, Epidural - continuous block- 5, sterods application - 9.
Results were evaluated as reduction of severity of pain in NRS after 24 hours and 10 days: very good and good - reduction more than 3 points, satisfied - 1-2, not satisfied - 0.
Results: Very good and good results were obtained in 25 patients (50%), satisfied in 13 (26.0%), not satisfied 12 (24%). In v. good and good results group, the dose of opioids was not changed, or reduced. In satisfied - the average increase of dose was 20 -32%. Not satisfied group required complex revision of treatment. No serious complication were observed.
Conclusion: Nerves blocks are valuable methods of cancer pain treatment. High range of positive results (76%) is a combination of two basic rules: precise pain diagnosis and early application of MIP.

PE 1.F337

Effects on pain and anxiety of holistic hospice nursing intervention program for in-patient of hospice palliative care unit

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Purpose: The purpose of this study was to test the effects on pain and anxiety of holistic hospice nursing intervention program(HHNIP) which was developed by CHOI for in-patient of hospice palliative care unit(HPCU). The design of this study was one-group pretest-posttest research.
Method: The subjects of study were 27 patients those who were over 18 years old and admitted in HPCU of S hospital in P city in South Korea with agreement in hospice palliative care in their terminal disease. The period of data collection was from April 6, 2004 to April 20, 2005. A HHNIP by CHOI was used as a tool for treatment in this study. And two tools to test for the effects of HHNIP were used in this study with a view of whole person: Brief Pain Inventory (BPI-K) by Young-Ho Yun(1998) to test the degree of pain in physical aspect, State-Anxiety Inventory by Spielberger(1975) to test the degree of state-anxiety in emotional aspect. The collected data were analyzed by Paired t-test with SPSS/WIN 12.0 program.
Results:
(1) Hypothesis No. 1: "The experimental group which received Holistic Hospice Nursing Program will have a lower degree of pain than before" was supported (t=-10.585, P= .000).
(2) Hypothesis No. 2 : "The experimental group which received Holistic Hospice Nursing Program will have a lower degree of state-anxiety than before" was supported (t=-8.234, P= .000).
Conclusion: As the results, this HHNI was testified for the effects on pain, state-anxiety. Its effects were proved by decreasing the degrees of pain and state-anxiety. Therefore it can be used actively for whole personal well-being of in-patients in HPCU and also can be applied in hospice practice as a useful program of multi-disciplinary team approach by hospice professionals.

PE 1.F338

Catalonia palliative care teams effectiveness in pain control of advanced cancer patients

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Aim: The effectiveness of PCT has been demonstrated in several studies In 2005 CATPAL group : "Effectiveness of symptom control in advanced cancer patients by palliative care teams in Catalonia, Spain".
The present research assess the effectiveness in pain control by different PCT acording to KPS.
Methods: Multicentre, descriptive study.
Patients with advanced cancer newly refered to PCT, with a follow-up check out after one week.
24-28/01/2005
Severity of pain (basal BP, episodic EP, nºepisod/24h NEP) by a verbal numeric scale VNS (0-10), registered day 1-7.
PCT: outpatient team OUT, hospital support team HST, unit team UNT, home support team HMT.
KPS subgroups:≤30, 40-60, ≥70.
Wilcoxon test, Xi-squared. SPSS 14.0.
Scientific Committee PC Service. Catalan Institute of Oncology.
Ethics Committee CEIC HU Bellvitge.
Results:
- 157 patients
- Age (mean) 70,55
- PCT 111 (75% total)
- PCT: OUT 30 p(19%), HST 30 p(19%), UNT 37 p(24%), HMT 60 p(38%).

PCT. Pain control

	day 1	day 1	P<0.05
OUT EP	7	6	0,239
NEP	3	2	0,251

KPS. Pain control

	day 1	day 7	P<0.05
KPS ≤30 EP	8	4.5	0,109
NEP	2	1.5	0,180
KPS ≥70 BP	3	3	0.056

Conclusions: The intervention of PCT show a significant decrease in the intensity of pain seven days after the first consultation.
OUT PCT partial pain control
KPS, ≤30 group, partial pain control (few number of patients and fragile situation).
KPS ≥70 group partial pain control (in correlation with OUT PCT group). Those patients have more than one specific care team at the same time (oncologist, radiotherapist?), and the coordination between them is not satisfactory as well It will be important to promote randomized studies and the ussefulness of promoting cooperation between PCT, and other professionals, to improve patients quality of life.

PE 1.F339

Sterntalerhof - therapy

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The goal of the Sterntalerhof is to accompany families in exceptional situations holistically. These situations include but are not limited to serious illnesses, disabilities, and traumatic experiences. Although special attention goes to our young guests, who are chronically and/or critically ill, the Sterntalerhof considers itself a rest stop (which is the original meaning of hospice) for all family members. Here they can find peace and strength in order to pursue their walk of life with more confidence. The Sterntalerhof team consists of a doctor, a spiritual counselor, a psychotherapist, a special education teacher, a social worker, a music therapist, and an art therapist. Its mission is to function as a bridge between complete medical care in a hospital and independence at home, where the family can rely on its own resources as a source for power and strength. With this in mind, the Sterntalerhof is simply there for families in need and available for one or more therapeutic stays.
Therapy: The core of our therapy is a holistic and family-centered approach. We offer spiritual (patient) care, bereavement counseling as well as terminal care. Our care focuses on our guests as a multi-dimensional unit in their physical, psychological and spiritual essence and considers the individual needs of each person as well as family. The palliative care aims to improve coping mechanisms for one's disease and contribute to our guests' quality of life. Additionally, the Sterntalerhof attempts to develop psychosocial help that meets the needs and psychodynamic background of each guest. Essential to our work are art therapy, music therapy, and therapeutic work with horses including therapeutic horseback riding. Our counsel and support are individual-focused and are complemented by the presence of our therapeutic horses. Our care enables deep human encounters and relationships in spite of disease and frailty and lets our guests experience their invulnerable dignity. Due to being gregarious animals, horses are especially suited for therapeutic interventions. Horses have expanded their competency in relationships to human beings as part of their domestication and allow for that relationship in the close physical contact during (therapeutic) horseback riding. The sensation of being carried and cradled - especially for people with a progressive course of disease - allows for the opportunity to build up wounded confidence and experience a deep feeling of security.
Target groups:
- Recovery for families with children after intense treatments
- Families with children with a chronic or progressive course of disease
- Families where one parent is critically ill
- Children and teenagers after traumatic experiences or losses.

PE 1.F340

„Sterntalerhof" - A rather different hospice for children

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The „Sterntalerhof" on its self-image (self concept) acts literally as an hospice for families, who carry heavy burden by looking after very sick or handicaped children. Here they will have a break, get the chance to breathe deeply, will be accepted as they are, stock up on physical and psychical strengths to be able to cut one's own path in familiar surroundings.
The sick child, siblings and parents receive professional and individual care as well as qualified medical and nursing attendence if necessary to enable them to cope with dilemmas during the last phase of life.
The target groups for the "Sterntalerhof" are:
Families with a child suffering from cancer;
Children with severe chronic diseases or after brain damage;
Children on palliative care with their parents and siblings;
Families with one parent suffering from a life threatening disease.
The therapeutical team consists of:
Psychotherapists, physiotherapists, pastor, music and art therapists, therapists on therapeutic vaulting;
in addition a mobile palliative care team with SRN's and a medical doctor qualified in palliative medicine and palliative nursing is available when needed.
"Sterntalerhof" also means, that there is always a place, time and attendance for dieing childen on spot.
Conclusion: A hospice for children is not equivalent to a hospice for adults. The "Children-Hospice Sterntalerhof" is a place for families with their sick child and the other kids to stock up physical and psychical strengths to enable them to get through their most important part of life - dieing at home. "Sterntalerhof" gives children a "today" because their tomorrow is written in the stars.

PE 1.F341

Voices of parents: The lived experience of caring for a child with a life-threatening and life-limiting diagnosis within existing social policies

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Aim: To describe, interpret, and link through voices of parents the lived experience of caring for a child with a life-limiting and life-threatening diagnosis within the context of existing social polices.
Methods: Critical ethnology and Habermas' critical theory framework provided a framework to deconstruct power structures and relationships to reveal and redress oppression by unlocking silent discourses, emancipating voices, and empowering families.
Results: Stories of six parents were captured and four themes emerged.
1. Mother as Caregiver, described the profound effect that assuming the caregiving role had on the lives of these mothers.
2. "Respite and Coping", explored and identified the overwhelming need for parents to obtain relief through respite, so they could parent better.
3. "Surviving Past Expectancy", explained how their child, outliving their initial diagnosis, placed another stress and burden on the family.
The final theme, "Getting Everyone on the Same Page", described frustrations parents experienced trying to find services and act as coordinator for their child and family.
Conclusion: This study provided a unique and valuable optic to an untapped data source, which until now has remained silent. The main findings were the untapped resilience and strength of each participant, the uniqueness of each of their stories, and the reality that the harms associated with having a child with a life-limiting and life-threatening diagnosis can certainly be lessened through social polices that direct the

provision and access to pediatric palliative care services to all who require them. A researched-based understanding of the lived experience and the contextual nature of parents' perceptions provides policy-makers, politicians, and health care professionals an opportunity to offer specialized services and programs to children with life-limiting and life-threatening diagnosis and their families.

PE 1.F342

Different approaches for the same disease in pediatric palliative care: Two cases of severe dyskeratosis congenita

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Background: Severe congenital disorders play a major role in pediatric palliative care. We report on 2 children suffering from a rare congenital condition: Hoyeraal-Hreidarsson Syndrome (HHS), a severe form of dyskeratosis congenita, causes progressive organ failure (haematopoiesis, immune system, intestinal mucosa) due to a mutation in a telomerase gene.
Patients: Two male pts presented at the age of 8 mo. (pat.1) and 3 yrs. (pat.2) with refractory diarrhoea and severe pain under enteral nutrition. Both received total parenteral nutrion and an ileostomy. Progressive immune deficiency led to the diagnosis of HHS in both cases. Both families decided against bone marrow transplantation due to the poor prognosis. The children were taken care of by the Munich Coordination Centre for Paediatric Palliative Care (CPPC).
Pat 1: Due to the parents' explicit wish for life prolongation, he received regular transfusions and activated factor VII because of severe bleeding from his ileostomy. After diagnosis he spent 30 mo. in hospital 400 km away from home. During the last 6 mo. of life the CPPC was able to establish home-based palliative care. The child died with 6 yrs. peacefully at home.
Pat. 2 was discharged after diagnosis. Home-based palliative care could be established in close cooperation between the CPPC and the family pediatrician, which allowed for successful management of pain crises caused by gastrointestinal obstruction. Re-hospitalisations could be avoided, the pt. died at 5.5 yrs. peacefully at home.
Conclusion: Because of the complex and poorly known symptoms, palliative care in children with rare diseases is a real challenge. A pediatric palliative care team can provide successful coordination of home-based palliative care and 24/7 counselling despite long distances. Even in children with the very same disease, the individual needs and values of the patient and family provide the guidelines for decision making and for any medical intervention.

PE 1.F343

Raising standards of care in residential homes for children from Romania. From dream to reality

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During the past years, Hospice "House of Hope" Brasov has become aware of the growing problem relating to children suffering from life-limiting or life-threatening illnesses, who are living in State-run institutions.
We started with a cooperation with the local authorities of Child Protection in 2005, aiming to improve the care of children with limited prognosis from state institutions. We did this through direct care of the children, education, organizational and management support.
The next step was trying to influence things at a national level. For this reason we started the project "Every child matters", which aimed to raise standards and provide equality of care for Romanian children needing palliative care, whether at home or abandoned and living in State-run institutions.
The project had 3 main components:
1) Lobbying the government and health care institutions to provide better care and resources for this group of children, including the publication of a "Minimum Care Standards" guide for children with a life-limiting or life-threatening illness, adopted by the authorities for child protection.
2) Medical and Practical assistance to children from Brasov county and their carers/family members to alleviate their suffering; (home visits and admissions in the in-patient unit).
3) Education for staff/carers involved in the care of these children.
Results: We succeed to form a working group from people working in palliative care, local and national authorities for child protection which elaborated a "Minimum Standards of Care for Residential Homes" and a guideline which give specific instructions about the provision of palliative care for children living in state institutions. The documents are now in the stage of legislative project which are to be adopted by Ministry of Social Protection.
Conclusions: The children living in state institutions deserve equal access to palliative care, and the "Minimum standards" will contribute to the provision of care.

PE 1.F344

Needs assessment for pediatric palliative care in a region of Austria

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The EAPC Task Force Pediatric Palliative Care set standards for pediatric palliative care. In this sense at the moment there is a lack for pediatric palliative care in Austria. We conducted a needs assessment for palliative care for children with life-limiting illnesses including an epidemiological approach and an analysis of the existing structures for palliative care in a province of Austria. In semi-structured interviews we evaluate the view of different stakeholders regarding the provision of palliative care, expertise in delivering end-of-life-care and wishes for the future.
In 2007 one hundred and one children, adolescent and young adults (0-25 years) died in Styria, 27 children of 'palliative care relevant' diseases. Most of the children died of congenital anomalies (48%) and malignant neoplasia (22%). The others distribute to disorders of the nervous system, diseases of heart and circulation systems, blood, digestion and respiratory organs.
Despite the fact, that the number of the children is small, the stakeholders identify a need for structured palliative care. In the interviews they shared the same wishes concerning training in palliative medicine and a development of a palliative care team who works in the whole province and cooperates with other palliative care services.
The present study delivered an insight into the situation of children with life-limiting illnesses which is comparable to the other regions of Austria. According to the small numbers of inhabitants in each province, these data allow to develop a model for the provision of palliative care in the whole country. A transition between settings could be achieved by founding of an interdisciplinary care team with special palliative care expertise. In this team the experiences of the adult palliative care service could be used. The offer of training in palliative care should be extended, one 'Center of Competence' could serve Austria.

PE 1.F345

Contributions of the hospice services to reducing the social isolation of disabled children and their families

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Background: The disabled children must be considered as part of the society. We shouldn' t hide them, we shoudn't pity them, but we need to support them to live along with other children.
Every child should benefit from equal chances to socialise. The reality in Romania is far from those ideals. Our society still look at the handicap as a stigma. Many disabled children are left out from kindergarten and schools. In time they are marginalised and will never be integrated in the society.
We organised complex social support interventions for children and families.
Aim: To evaluate the impact of social support offered by hospice to reduce the social isolation in which these children and families live.
Method: 30 families received questionnaries to evaluate the effects of the participation in the day-centre, educational centre, summer clubs, summer camps and support groups for reducing the social isolation of their children and to induce resilience in their family.
The indicators used in the evaluation of the socialisation process were qualitative: the relationships which were built, the interest for the proposed activities, the satisfaction degree expressed by children and their parents, if they continued to meet after the programme ended and quantitative: the number of children which responded to invitations, numbers of meetings and number of activities in which they participated.
Results: All the parents/children rated the interventions as helpful. Many of them said that they don't feel isolated any longer because of the social support which they received.
Conclusion: Qualitative and quantitative data indicate beneficial effects of interventions for disabled children and their families. Frecventation of day centres and other social events, not only give the possibility to spend few pleasurable hours, but also bring meaning and dignity in the life of children needing palliative care in a society which often neglects the needs of most needed.

PE 1.F346

Invasive diagnostic and therapeutic measures in pediatric palliative care

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Introduction: In pediatric palliative care there are often situations requiring difficult decisions, especially concerning the usefulness and necessity of invasive diagnostic and therapeutic procedures. We report 2 patients where difficult decisions led to positive outcomes.
Patient 1: The $2^{3/4}$ yrs old boy suffered from Menkes Syndrome, a copper malabsorption disorder leading to quadriplegia, severe epilepsy and mental retardation. In the past he suffered from severe pain of unknown etiology which had been treated with morphine and tetracannabinoids. Due to acute, therapy-refractory pain an x-ray and abdominal contrast radiography (ACR) were performed, which showed a diaphragmatic hernia with bowels in the thorax. After discussions with parents, surgeons and anaesthetists, an operative repair of the hernia was performed. The severe pain ended promptly after surgery, and pain medication could be reduced. After 3 months of good health, acute pain ensued again due to a contralateral diaphragmatic hernia. The patient died after surgery due to cardiac failure.
Patient 2: The 2 yrs old patient is a microcephalic and severely handicapped boy who suffered from gastroesophageal reflux disease and poor weight gain. Three months after placement of a percutaneous enterogastrostomy (PEG) he developed massive abdominal cramps and weight loss. His parents asked us whether fluids and nutrition could be withdrawn to end his suffering. Since the origin of his symptoms was unclear, we convinced the parents of the need for further diagnostic measures. An ACR showed a wrong placement of the PEG in the colon. A new PEG placement resulted in immediate resolution of symptoms and subsequent weight gain.
Conclusion: In pediatric palliative care, the burden of diagnostic measures as well as the wishes and attitudes of child and parents require careful consideration. However, when severe symptoms are unexplained, appropriate diagnostic and therapeutic measures, even if invasive, are warranted.

PE 1.F347

Pediatric palliative care in spinal muscular atrophy type I (SMA I) - Individual counselling regarding therapeutic decisions

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Background: SMA I causes progressive muscular weakness and death through respiratory insufficiency during the first 2 years of life if no mechanical ventilation is started. Decision making regarding ventilation and palliative care can differ significantly

between families.
Case vignettes:
Pat.1: Diagnosed at 6 wk, 1st re-hospitalisation (RH) at 10 wk due to dyspnoea. Parents refused ventilation, the Munich Coordination Centre for Pediatric Palliative Care (CPPC) was involved. Re-admission to the ICU with severe dyspnoea, O2-therapy and iv morphine. Pt. died on ICU at 11 wk.
Pat. 2: Diagnosed at 7 mo., 1st RH at 12 mo. with dyspnoea, recurrent intubations, CPPC involved. Discharged home with non-invasive ventilation. 2nd RH at 16 mo. due to RSV-infection. Different attitudes towards therapy between the parents. Tracheostomy and discharge with invasive ventilation. 3rd RH at 18 mo., pt. still alive at 26 mo.
Pat. 3: Diagnosed at 12 wk, non-invasive ventilation initiated at 11 mo., CPPC involved. Acute respiratory deterioration while inpatient, parents refused tracheostomy, pt. received iv fentanyl and died at 13 mo. on ICU.
Pat. 4: Diagnosed at 5 wk, RH at 3 mo. due to pneumonia, O2-therapy, discharged home. CPPC involved in acute respiratory crisis, home visit and admission to children's hospital. Improvement due to physiotherapy and O2. 2 days later acute deterioration with severe dyspnoea, no intubation, iv morphine. Died at 4 mo. in hospital.
Pat. 5: Diagnosed at 6 wk, parents refuse ventilation. Multiple home visits by the CPPC. Admission to children's hospice at 4 mo., treated with oral morphine and lorazepam. Good quality of life. Died at 5.5 mo. in children's hospice.
Conclusions: Decision making can vary significantly in children with SMA I. Medical facts, personal values and hopes of the family as well as their resources need to be considered. A pediatric palliative care team can offer counselling, support and care coordination to the families.

PE 1.F348

From arbitrariness to desirability; Palliative care for children in the Netherlands

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Introduction: Palliative care for children is getting more attention over the last few years. More people and organizations are becoming aware of the need to respond to the specific situation and problems of these children and their families. To priotize actions and organize improvements, it is necessary to know how daily practice works, who are involved and in what way and what the experienced problems are.
Aims: To get insight in: the care network of children in palliative care, the organizational and other favourable obstacles in this care and possible ways of solution.
Study design and methods: We used the following methods: focusgroup - and individual interviews, questionnaire, ´open space´ working conference.
Results: In palliative care for children two different networks exists; a primary one consisting of persons and organizations in the near surrounding of the child (GP, hospital - and primary care professionals, close family and friends, health insurance etc) and a more extensive one. This latter network can include: consultants, all kind of therapists and psychosocial caregivers, transport services, employer(s) parents, education, funeral service etc.
Obstacles can be classified in five themes: child & parents, structure & organization, commitment & attitude, information, expertise. The possible solutions can also be classified: continuity, coordination & gearing of activities, knowledge, becoming conscious, giving attention, practical solutions.
Conclusions: In general, palliative care for children is too much dependent on positive intentions and the coincidental existence of knowledge and expertise. Because of this situation, fragmentation, problems in the gearing of people and activities and parents becoming overburdened often is the case. Based on the results of the study, a network of professionals concerned with palliative care for children is making a plan of action which will be carried out in the coming years.

PE 1.F349

The Soweto Hospice Caregiver and Child Empowerment Unit: Empowering the disempowered

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Social problems of caregivers and children are resulting in lengthy, protracted hospice stays for paediatric inpatients, often outliving the initial reason for encounter and acute medical conditions. Excellent unilateral medical care from healthcare providers is disempowering caregivers; bringing about feelings of inadequacy and promoting neglect. Caregivers may handover responsibility for their child´s disease process and progress to the healthcare provider and take a back seat to their child´s illness. Ignorance, non disclosure, fear, language barriers and lack of knowledge and counseling surrounding childhood illnesses causes caregivers to default treatment or give substandard care. The Caregiver and Child Empowerment Unit, a new initiative by Hospice Soweto, aims to empower children and their caregivers to reach their potential (no matter their background) through health education and skills training, subsequently decreasing future admissions or increasing time between future relapses. The objective is to provide an inpatient, interactive, intensive, four week program, facilitating feasible and economical ways to provide resources, skills and knowledge to the family unit through the primary caregiver. Aspects receiving particular attention include: Child care; Nutritional counseling with practical cooking skills and applications; Childhood development and stimulation at age-appropriate levels for each child; Health talks regarding both child and maternal health as well as general topics; Support groups, which may be extended into communities; Financial skills, regarding individual marketing and preparing relevant documentation e.g. CV, budgets, bank accounts, savings plans and application to social services; as well as initiating income generation projects with extension into the communities as micro-businesses. Caregivers and children are assessed at an individual level and are supported so as to achieve their greatest potential.

PE 1.F350

The ICPCN - An international resource to promote and assist the worldwide development of palliative care for children

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The first children's hospice, Helen House in Oxford, was begun by Sister Frances in 1982 - 15 years after the start of the first adult hospice. Since then the children's hospice movement has lagged behind the general hospice movement.
New children's hospices are developing steadily around the world and adult palliative care services are becoming more aware of the very different needs of children. Advocacy for the right of children to paediatric palliative care is also increasing.
In response, the International Children's Palliative Care Association (ICPCN) was formed in 2005 as a network of organizations and individuals working in the field of palliative care for children. It is part of the Worldwide Palliative Care Alliance where it plays an advisory role on issues related to children and adolescents and ensures that children are included in all policies and programmes.
The ICPCN shares a vision that the total needs of life-limited children and their families should be met and its mission is to promote the world-wide development of children's palliative care through providing opportunities for networking and shared learning for those involved in children's palliative care internationally; and to provide a central resource of information.
Some objectives
• To provide a "One-Stop Shop" information system managed by an International Information Officer
• To pilot and review a programme of expertise - sharing through visits and exchanges by providing scholarships
• To ensure children's palliative care is included in international meetings, journal articles and national associations
• To develop a fund to support the activities
• To carry out a survey of existing hospice and palliative care services and from this to identify gaps in provision.
Some challenges
• Raising funds for exchange visits
• Raising the profile of palliative care for children
• Expanding training in Children's Palliative Care
• Increasing the reach of palliative care for children.

PE 1.F351

Home-based palliative care in children: The Coordination Center for Pediatric Palliative Care at the University of Munich

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Background: Most children with life limiting diseases and their families wish to spend as much time as possible together at home. However, the majority of the 600 children and adolescents who succumb to life limiting diseases every year in Bavaria die in hospital. This situation led to the development and implementation of the Munich University Coordination Center for Pediatric Palliative Care (CPPC) in 2004.
Project description: In order to improve quality of life of children with life limiting diseases the multiprofessional CPPC team works in the following main areas: coordination of home care, networking and identification of resources, education and teaching.
Results: Between 3/04 and 5/08 the CPPC took care of a total of 149 patients (median age 5 y, range 7d-43y). In 7 families prenatal palliative care was provided. 88 pts died so far. Most children suffered from congenital malformations/diseases (27%), neoplasm (23%) or neurological diseases (18%). In 72% of pts the CPPC team was recommended by pediatric specialists in the hospital, in 22% the family itself asked for CPPC support. The leading symptoms in more than 50% of pts were pain and dyspnoea. Under the care of the CPPC 92% of the children aged 1-16 yrs and 41% of children <1y died at home (compared to 50% and 10% in Bavaria in 2005, respectively). The working group for pediatric palliative care at Munich University Hospital organised three bi-annual symposia on pediatric palliative care since 2004. In the last 4 years, 134 health care professionals of Munich University Children's Hospital attended an in-house training in pediatric palliative care organized by the CPPC. Currently, a concept for pediatric palliative care for the whole of Bavaria based on the CPPC model is being developed in cooperation with the Bavarian Social Ministry.
Conclusion: CPPCs can improve the quality of pediatric palliative care, optimize the utilisation of existing resources and enhance the dissemination of knowledge.

PE 1.F352

The value of play within paediatric palliative care

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Childhood is a time of continuing growth and development, adversely affected by life-limiting and chronic illness such as HIV/AIDS. A survey amongst children and their parents within a group of hospices in South Africa revealed that most children rated having opportunities to play as being only slightly less important than food and shelter. Most adults surveyed scored play near the bottom of their list of a child´s needs. Promoting normal childhood development within palliative care improves quality of life and develops self-esteem, improved communication and social skills, and the ability to express negative and positive emotions through play, art, music and words. While health professionals focus on the clinical treatment of children with illnesses such as HIV/AIDS and TB in Southern Africa, it is of equal importance to focus on their psychological health and wellbeing.
"Through play the child expresses traumatic fixations, conflicts and hostilities. The child also uses play to disguise genuine conflicts and difficulties, or he may use play to relax tension and anxiety. Of greatest importance is the fact that he discharges aggression and seeks to overcome traumatic anxieties through play; it acts as a regulative mechanism."
Understanding Children's Play By Hartley, Frank and Goldenson.
Chronically and terminally ill children have an even

greater need for the distraction, psychological benefits and the developmental stimulation that play provides. Hospice and paediatric palliative care centres in South Africa are realising the value and importance of promoting play within their programmes.
I have written a handbook entitled "Promoting Early Childhood Development within Paediatric Palliative Care" that covers the developmental stages of children, emphasises the importance of play and how to incorporate this knowledge into a comprehensive and holistic daily programme for vulnerable children in an African palliative care setting.

PE 1.F353

Evidence based modelling of the trajectory of life-limiting conditions: Are the ACT categories valid?

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Aim: to begin to validate the ACT/RCPCH categories by providing the first step towards generating testable models of life-limiting conditions.
Patients and methods: Phase 1, four focus groups were convened comprising medical/PAM, education and social care professionals from South Wales with an interest in PPC. Semi-structured discussions used vignettes from each ACT/RCPCH category. Phase 2 interviews were carried out with families of children with LLC under the care of the Specialist Paediatric Palliative Care/Symptom Control Team at the Children's Hospital for Wales. They were purposively selected to encompass all four ACT/RCPCH categories. Semi-structured interviews followed a schedule derived from phase 1 and focused on specific important experiences. Interviews were audio recorded, transcribed and analysed using computer assisted qualitative data analysis software.
Results: Phase 1: 25/38 professionals from 14 backgrounds approached agreed to participate. Phase 2: 30/76 families approached agreed to participate, of whom 4 withdrew or were not suitable. There were four, three, seven and 12 families categories I, II, III, and IV respectively, total 26). In 9/26 families, their child was no longer alive. In 8/26, two individuals were interviewed. There were 24 mothers, nine fathers, one sibling and two foster carers).
Thirty-four milestones in 5 phases were identified. Some occurred in all categories, others only in some. The phases were: Diagnosis, Loss of normality, Adjusting to new normality, Palliative phase, Death.
Conclusion: Milestones fell into five similar phases in all four categories. Many were common to all four groups, suggesting the ACT/RCPCH categories describe a group of conditions that have something in common. Other milestones occurred in only three, two or even one of the ACT/RCPCH categories arguing that trajectories of conditions in the four categories are distinct from one another.
This provides preliminary evidence that the ACT/RCPCH categories are valid tools for research and service development.

PE 1.F354

Correlation of DEGR and Oucher pain scores in children with cancer: What can it tell us about the nature of chronicity in children's pain?

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Aim: To validate the Douleur Enfant Gustave-Roussy (DEGR) by exploring its relationship with the well-established Oucher pain scale using standard correlation techniques, and to explore the chronicity of children's pain by comparing the changing relationship between Oucher and DEGR scores.
Patients and methods: Clinical methods comparison and correlation pilot study. Participants were children aged 3 - 19 years receiving treatment for pain related to cancer on an regional specialist oncology ward. Children's pain was scored in parallel using DEGR administered by the ward nurses and Oucher administered by a research nurse.
Results: Thirty families agreed to participate in the study and were recruited. Pain score data were incomplete for nine. 143 DEGR scores and 92 Oucher scores were obtained. Scores from either scale were discarded if too remote from their paired score from the other. Forty-six complete sets of paired data were obtained from 21 subjects.
Oucher scores fell to zero while DEGR scores remained significant. Relationship between the scores using the two scales was complex, with reasonable agreement at lower scores and the Oucher reading higher than the DEGR at higher scores.
Conclusions: Our data suggest that the DEGR is more sensitive to chronic pain than the Oucher, while the Oucher is more sensitive to acute pain than the DEGR. Behaviour patterns associated with chronic pain in children begin to become apparent after only seven to fourteen days. Caution may be necessary in interpreting data from faces-type scales beyond this.

PE 1.F355

Dose-response and serum levels: Morphine and M6G in children with cancer

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Aims: To examine the relationship between analgesia and serum morphine and M6G concentrations in children with cancer.
Patients and methods: Seven patients under the care of the regional Paediatric Oncology Unit in Cardiff and the Vale NHS Trust who were prescribed morphine. Six blood samples were drawn from indwelling venous lines at intervals between administration of morphine and 8 hours after its discontinuation. Morphine was analysed using high performance liquid chromatography (HPLC). Its active metabolite, morphine-6 glucoronide (M6G), was measured using a highly sensitive enzyme linked immuno-sorbent assay (ELISA). Pain was assessed using a simple Faces scale, each time a sample was withdrawn.
Results: Pharmacokinetic profiles were obtained in 7 patients ranging in age from 2.4 to 16.4 years (median 7.6 years). Pharmacokinetic parameters for M and M6-G were comparable with those of previous studies. The half life of M6-G (329 minutes) was considerably larger than that of M (140 minutes). Clearance of M was higher than in adult studies. Side effects were: drowsiness (7/7, 100%), nausea and/or vomiting (4/7, 57%), pruritus (2/7, 28%), urinary retention (1/7, 14%). There were no reports of respiratory complications. Pain scores varied between 1 and 4 out of 5. There was no correlation with serum concentrations either of morphine or M6-G, or the molar ratio of the two. Maximum serum concentrations were comparable with other studies.
Conclusion: This study provides preliminary data suggesting that children remain in pain despite significant serum concentrations of morphine and M6-G. The relationship between serum concentrations of opioid and relief of pain is not straightforward. Some adverse effects, particular nausea and pruritus, may be commoner than is usually thought, while others (particularly respiratory problems) did not occur at all in this series.

PE 1.F356

Conveying compassion to the dying elderly through attention to the essential ordinary

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Compassion is a hallmark of palliative care. The literature upholds the import of being compassionate, but has few descriptions of how this is done. The aim of this study was to explore ways which nurses convey compassion to the dying elderly. The elderly in this study were over 65 and dying from a disease other than cancer. Compassion was defined as sensing another's suffering combined with a desire to alleviate or reduce such suffering.
The research design was descriptive phenomenology. A purposive sample of 7 nurses were found by network sampling. Data sources were semi-structured interviews and observations of nurse-patient interactions. The one hour private interviews began by asking, "How do you convey compassion to the elderly people you care for who are dying?" Interviews were recorded and transcribed. Observations were noted in a journal. Narrative analysis involved reading and re-reading data, highlighting phrases expressing a key idea, and grouping elements to identify themes. Study limitations include small sample and investigator bias. Further research that includes quantitative elements and a larger sample is suggested.
The core theme was attention to the "essential ordinary." The essential ordinary are tasks of everyday living such as eating, sleeping and bathing that are not given much thought until something occurs which prohibits one from doing them. The nurses in the study found assisting the dying elderly with essential ordinary acts as routes to convey compassion. How they went about helping patients with the essential ordinary is described in sub-themes: (a) attention to the "simple things," and (b) keeping the promise to never abandon. The findings were further analyzed using Salvage´s social construction of caring.
The study has relevance for all carers. Both participants in a compassionate interaction may be affected. This is discussed using Watson' theory of transpersonal caring and MacRae's social construction of compassion.

PE 1.F357

Dronabinol in palliative medicine

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Aims: We examined the efficacy and the adverse effects of 2.5% dronabinal drops in the indication of nausea, vomiting, and inappetence on the palliative care unit of the Klagenfurt regional hospital.
Methods: 45 patients were enrolled: 24 males and 21 females whose mean age was 70.2 years, and whose mean weight was 61 kg.
The patients had the following disorders: 11 patients with Neoplasm of the colon, 9 patients with Bronchial neoplasm, 5 patients with Neoplasm of the pancreas, 2 patients with Breast cancer, 2 patients with Oropharyngeal neoplasm, 3 patients with Neoplasm of body of the uterus, and 5 patients had other carcinomatous diseases.
The mean period of observation was 12 days. The starting dose of dronabinol was 2.5 mg b.i.d. If, after three days, there was no adequate symptom relief, the dose was increased to 5 mg b.i.d.
Results: The dose was again increased to 10 mg b.i.d. if there continued to be inadequate effect. The mean dronabinol dose over a period of 10 days is shown in figure 1. A slight improvement trend was achieved with respect to nausea and there was a significant reduction in the incidence of vomiting. The incidence of inappetence was also clearly reduced. No adverse effects were observed at these doses.
Because in some cases dronabinol dosed b.i.d. does not produce sufficient effect in the patients, we now use dronabinol t.i.d. We start with 2.5 mg dronabinol t.i.d. If, after 2-3 days there is insufficient improvement in symptoms as to nausea, vomiting, and inappetence, the dosage is increased to 5 mg t.i.d. up to a maximum dose of 10 mg t.i.d.
Conclusion: The use of dronabinol was considered under the following requisites:
In patients in whom other analgesics did not have the desired effect or were not tolerated. In patients who benefit from dronabinol´s broad profile of activity (analgesia, antiemesis, appetite enhancement, mood elevation) as in palliative medicine, oncology.

PE 1.F358

Transitions to palliative care for older people in acute hospitals in the UK

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Aims: Addressing the ´substandard´ care older people receive at the end of life is a key public health concern. An area of particular policy priority is palliative care provision in acute NHS hospitals in the UK where a proportion of dying patients receive very poor care. This large scale three year Department of Health funded study (over £460,000) will explore the need to improve care for older people at the end-of-life. It aims to examine how transitions to a palliative care approach are managed and experienced in acute hospitals and to identify best practice from the perspective of older patients and key service providers.
Methods: A case study design using a mixed method approach wil be used in two contrasting acute NHS hospitals in England. Methods will include:
(1) a census of palliative care needs amongst inpatients, collecting information from patients, medial and nursing professionals working in primary and secondary care;
(2) case note reviews;
(3) interviews and focus groups with key health and social care professionals and service commissioners;
(4) interviews with older people identified in the census as having palliative care needs on two occasions, six months apart;
(5) an economic evaluation measuring the proportion of hospital patients with palliative care needs where admissions were termed ´inappropriate´ and that episode of care could have been provided in a community setting.
Results: The study will commence in January 2009. Whilst findings will not be available, the poster presentation will provide a detailed account of the proposed methodology and sample, together with an examination of the complex ethical and methodological challenges involved in examining the transition from ´active treatment´ aimed at cure or chronic disease management to palliative care in the context of two acute hospitals, the care setting that currently delivers end of life care for the majority of the population.

PE 1.F360

Experiencing cancer in old age: A qualitative systematic review

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Aim: The aim of this study was to report and interpret the findings of qualitative studies which investigated the experiences of older people living with cancer.
Methods: Systematic literature searches were conducted using:
i) searches of electronic bibliographic databases, with a 'filter' to maximise the yield of qualitative studies;
ii) hand searches of purposively selected journals;
iii) follow-up of references;
iv) author and expert panel consultation. Papers were included if they were reports of qualitative research investigating older peoples' experiences of living with cancer and were written in English.
Findings from included studies were located, extracted and analysed using a process of topic identification (grouping), abstraction (summarising) and interpretation.
Results: Eleven studies were included. Four hundred and fourteen findings were located. Findings were grouped into 19 topics which were summarised in 5 core topics/themes: empowered patients; bodily signs and symptoms; treatment; relationships; states of mind and feeling induced by living with cancer. The interpreted findings suggest that to live with cancer in old age is to live in a perpetual state of ambiguity. The experience is characterised by a sense of disintegration, diminished identity, suffering and social retraction. At the same time these experiences are balanced by sources of comfort and strength found within the self and among relationships with family, friends, health care providers and community.
Conclusion: These findings illuminate the complex, multi-dimensional character of living with cancer in old age. They show that older people living with cancer are resilient as well as vulnerable. The results of this study reveal positive practice on the part of health professionals but also show where changes in attitudes and behaviour would enable more empathic understanding of older peoples' life situation and facilitate a more effective fostering of their resilience.

PE 1.F361

Quality of end-of-life policy in the elderly: Differences between geriatric and non-geriatric wards?

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Aim: The objective of this study was to compare the quality of EOL decisions in an elderly population admitted on a geriatric versus non-geriatric wards.
Methods: Following quality indicators of a hospital EOL policy were used: dying at Intensive Care Unit (ICU) versus non-ICU and frequency and quality of Do-Not-Resuscitate (DNR) decisions. Data were collected in all older patients who deceased during a 12-week period in 2007 and a 16-week period in 2008 and who were admitted at least 2 days on a non-ICU ward in their final hospitalisation (in whom it was possible to address EOL issues).
Results: 72 deceased patients were 75 years or older. The comorbidity did not differ between older people dying on geriatric versus on non-geriatric wards (in both groups: mean Charlson comorbidity score of 6, p=0.486). Quality indicators of EOL policy are listed in table 1. Patients admitted on geriatric wards were less frequently referred to the ICU at the EOL.

	All deaths		Patients dying on non-ICU				
			No DNR	Patients dying without DNR form			
	Dying on ICU (p=0.048*)	ICU stay last episode (mean length of stay in days) (p=0.117)	Dying without DNR form (p=0.216)	Code 0 (full therapy) or 1 (no CPR only) (p=1)	First decision to limit therapy within 48 h before death (p=0.432)	Information patient / family (p=0.379)	Participation nurse (p=682)
G-ward (n=26)	4%	19% (2 days)	16%	5%	5%	86%	60%
Non-G ward (n=46)	22%	37% (3days)	6%	6%	0%	94%	66%

Conclusion: Despite similar Charlson Comorbidity score and subsequent long-term prognosis, patients, 75 years and older, dying in hospital were less frequently admitted to the ICU when hospitalized on an acute geriatric ward.

PE 1.F362

'Partners in care' - Progress of nursing home palliative care LINK nurse scheme

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Background: The Palliative Care LINK Nurse Scheme was launched in 2006 to improve partnership working and meet the educational needs of the Care Home industry, which is a major employer in the area. The area of 235,000 residents has a high elderly population and 23% of ALL deaths (14% of cancer deaths: 24% of non cancer deaths) take place in Care Homes.
Scheme: To date 31 Nursing Homes belong to the scheme. Each of these homes nominates a LINK Nurse from their staff group and a has a named Community Palliative Care Nurse Specialist allocated to their home as a resource and contact.
Audit & results: A audit of the effectiveness of the LINK Nurse scheme was undertaken in 2007 and demonstrated increased confidence and reduced anxiety relating to end of life care. In 2008 an audit of other staff in the LINK Homes showed the recognition and impact of having a LINK Nurse within their home. As a result of the increase in the number of Care of the Dying Pathways (Liverpool Care Pathway) used to support dying in these homes, a pathway facilitator was funded to further encourage the use in these homes and to increase uptake of those homes not yet involved in the scheme.
This poster shows the results of the two audits and the effect, so far, of the facilitator post.

PE 1.F363

The views, experiences and needs of older lesbians, gay men and bisexual people about end of life care

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Background: There is recognition that palliative and end of life care should address the needs of minority groups, including lesbians, gay men and bisexual (LGB) people. While many concerns relating to end-of-life care are the same across all communities, there are also separate issues related to sexual orientation that need to be addressed. The experiences and concerns of older LGB people relating to palliative and end-of-life care have received scant attention in the research literature.
Aim: To conduct an exploratory study to investigate the views and experiences of older LGB people living in England relating to end of life care and the extent to which they feel their needs are addressed by current palliative care provision.
Method: We carried out six focus groups with LGB people who defined themselves as 'older' in the north and south of England. 11 men and 4 women too part. 4 were aged 55-64; 4 aged 65-74 and 1 aged 75-84. One person under the age of 45 participated. 4 declined to give their age. Several wrote up case studies of their own experiences. Data was analysed using a framework approach.
Findings: Specific concerns and needs were reported in relation to end of life care linked to sexual orientation. These include discrimination and care provision that is insensitive to the needs of LGB people. These experiences mean that many older LGB people are reluctant to disclose their sexual orientation. Traditional definitions of the family do not always apply to LGB people who report that their 'family' are their partner or close friends.
Conclusions: The ageing LGB population in England is a significant minority who have a range of experiences and concerns about end of life care. This exploratory study shows that it is possible to access the views of minority groups about end of life care. There is a need to elicit these views to inform strategies for developing appropriate and acceptable services for all.
Funding: Burdett Trust for Nursing.

PE 1.F364

Better practice in palliative care for older people: A new WHO guide

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Background: Populations in European and other developed countries are ageing, and more people are now living with the effects of serious chronic illnesses towards the end of life. Meeting their needs presents a public health challenge. Our earlier WHO guides explain why health services should provide good quality palliative care for older people. This EAPC task force, funded by the Maruzza Lefebvre D'Ovidio Foundation, seeks to build on these to provide examples of better palliative care practice, to aid those involved in planning and supporting care-orientated services in the most appropriate and effective way.
Aim: To describe a new WHO guide which provides examples of better palliative care practice.
Methods: A team of international contributors, with accepted knowledge and expertise in palliative care for older people are participating in planning and developing the guide. The new guide provides brief case studies of good and promising practice along with evidence of their effectiveness in the context of the WHO health systems principles and framework. Examples were sourced through systematic literature reviews and an international call through international

organizations. They were independently evaluated by three reviewers to determine which examples were most appropriate for the guide.
Results: Although a wide range of examples were considered for inclusion in the guide, many had not been rigorously evaluated and costs were rarely reported. Examples focusing on specific symptoms such as pain, advanced care planning, education and palliative care for older people being cared for in different settings such as care homes, larger regional or national initiatives and examples from developing countries are included in the guide.
Conclusions: The new guide will be widely disseminated. It will provide a resource for policy makers to improve palliative and end of life care for older people in Europe and beyond.

PE 1.F365

Providing end of life care in care homes for older people: A qualitative study of the views of staff, residents and their families

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In view of the growing number of people in Europe dying in care homes for older people, it is important to explore views on providing end of life care (EoLC) in this setting. The aim of this study was to explore the views of care home staff, community nurses, residents and their families on providing EoLC in care homes for older people.
Methods: Semi-structured qualitative interviews were conducted with 33 managers, 29 care assistants, 28 nurses, 16 residents and 15 family members. The framework method of qualitative analysis was used to explore and compare participants' views. This comprised five stages: familiarisation; identifying a thematic framework; indexing; charting; and mapping & interpretation.
Results: Five higher order themes emerged:
(i) initiation of EoLC;
(ii) the meaning of EoLC;
(iii) the significance of the care home environment;
(iv) stressors at the end of life (eol); and
(v) improvements in EoLC.
While some viewed admission to the home as an initiator of EoLC, others relied on a variety of triggers to recognise transition to the dying phase. Central to care provision was a constant care & attention, focused on providing optimal care to dying residents. Emphasis was placed on a tender loving style of care, where staff engage more intensely with the dying. The care home environment was considered important in providing this care, and to facilitate a better eol experience. Stressors which made it difficult for carers to cope with the eol, included attachment to residents, dealing with families and staffing levels. Some felt the level of support for carers was inadequate. Staff acknowledged improvements were needed, as carers lacked skills, experience and confidence when dealing with death and dying.
Conclusion: Despite a care focused attitude in homes, a number of barriers and challenges exist which may limit the quality of EoLC. Training needs of staff and improved support networks are discussed.
The study is funded by Guy's & St Thomas' Charity.

PE 1.F366

Relationship between different stages and diagnoses of dementia and the use of pain medication in nursing home patients

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Aim: To explore the relationship between nursing home patients with different stages of dementia and different dementia diagnoses and use of pain medication according their pain intensity I a cross-sectional study.
Method: 181 consecutive, long-term stay patients, 43 primary caregivers, one geriatric study nurse, and 4 physicians of a Norwegian nursing home. Admission records, prescription lists, care plans, Mini-Mental State Examination, Statistical Manual of Mental Disorders (DSM-IV), international classification of diseases (ICD-10), cerebral computer tomography, pain diagnoses and pain locations by physicians' examination, and pain intensity by MOBID-2 (Mobilization - Observation - Behaviour - Intensity - Dementia) Pain Scale, a novel staff-administered pain tool in dementia.
Results: Patients with severe dementia do not experience less pain intensity (P = 0.079), numbers of pain diagnoses (P = 0.172), and pain locations (P = 0.202) compared to other stages of dementia. Severely demented patients receiving opioids demonstrated higher pain intensity (mean 4.4, SD 1.7) than non-demented (mean 2.9, SD 1.8), and received less pain treatment (P=0.018). Pain intensity did not differ between diagnostic groups of dementia (P = 0.439). Patients with mixed dementia receiving opioids had more pain (mean 5.3, SD 1.5, range 4-7) than mentally healthy control and received less pain treatment (P < 0.005).
Conclusion: Patients with severe dementia and mixed dementia are at high risk to suffer by severe pain. More research and quality improvement programs and a multidisciplinary approach are needed to increase the knowledge in pain treatment by staff, which requires competence in both pain assessment and dementia.

PE 1.F367

Spiritual end-of-life care in Dutch nursing homes: A mixed method study

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In this study we map out spiritual end-of-life care in Dutch nursing homes. Although nursing home physicians are concerned with end-of-life care and bear final responsibility for the care, it is unknown if and how nursing home physicians map spiritual needs, how they provide spiritual care, how they deliberate with other caregivers and when and to whom they refer to. It is also unknown if and how spiritual care is provided to nursing home residents in different stages of dementia and to their families.
We aim at understanding if and how physicians provide spiritual care to nursing home residents -including residents with dementia- and their relatives.
A mixed methods design is employed, using both qualitative and quantitative research methods.
1. A systematic literature review of content and meaning of concepts of spiritual care.
2. A focus group study with Dutch nursing home physicians to understand the concepts' usefulness in practice for end-of-life care to residents and their families.
3. The results of the systematic review and focus group study will be used to develop a survey for a representative sample of Dutch nursing home physicians, to quantify spiritual end-of-life care. The results will be linked to the spirituality of the nursing home physician.
4. In the ongoing 'Dutch End of Life with Dementia Study' associations will be assessed of characteristics of nursing home, nursing home physician and residents with actually provided spiritual end-of-life care.
5. The review and the focus group study will provide key concepts to frame observations in an ethnographic study in Dutch nursing homes to study physicians' spiritual care.
6. All results will contribute to the development of recommendations and guidelines for nursing home physicians to improve and provide high quality spiritual end-of-life care.

PE 1.F368

Hospice and palliative care in Austria nursing homes

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Hospice Austria, the umbrella organisation of more than 200 hospice and palliative care organisations, is planning to introduce hospice and palliative care into nursing homes throughout Austria. Hospizbewegung Vorarlberg conducted 12 trials in one Austrian state to test the implementation and development of such care in nursing homes.The proper care of the elderly is one of the greatest challenges of the 21st century. Single elderly women make up the highest percentage of the elderly population. Many residents in nursing homes suffer from terminal illness and progressive diseases and a high proportion suffer from dementia.The trials have brought to light the importance of coordinating all the different processes and training schemes within the organisation. Nursing homes need external expertise in hospice and palliative care not just for the care of the residents but at management level. Continuous training in palliative geriatrics should run alongside this, to ensure that training is kept up-to-date with new developments and remains sustainable into the future.This internal coordination and expansion will create a culture of palliative care within nursing homes. And when such a system of care is realized, the special needs of palliative care can be clearly identified. The main topics for discussion are: holistic pain-relief, ethics, rituals, spiritual care and the subject of dementia. Gender and intercultural matters are both important inter-related issues which also need to be addressed.Politically each federal state will be responsible for all aspects of implementing such hospice and palliative care in nursing homes, from finance to contents and regulation. The result of this coordination and cooperation between all the federal states will be a much greater understanding of the need for hospice and palliative care within nursing homes, so that the elderly can enjoy a high quality of life to the end of their days and are allowed to die with dignity.

PE 1.F369

Implementing ´end of life care tools´ into nursing care homes: an integrated approach

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As a result of the 'end of life care strategy' (DoH 2008) in the UK, different settings are being challenged to improve the quality of care in the last months of life of people dying from any disease. Care homes in particular are being targeted because of changing demographics with the emphasis to reduce inappropriate admission to hospital of frail older residents. Various tools are being advocated - the most appropriate for care homes being that of the Gold Standards Framework for Care Homes and an adapted Liverpool Care Pathway for the Last Days of Life.
This abstract reports the findings of a 'realistic evaluation' study where the GSFCH and the LCP were introduced to 7 nursing care homes in one primary care trust. The implementation used 'high' facilitation because of the 'weak' context of nursing care homes. One full-time facilitator worked alongside the homes. A mixed methods evaluation was undertaken: a retrospective review of the notes of 238 residents; interviews with relatives whose family member had died in the care home both before and after the implementation. The quantiative data will be presented.
Results: There was an increase in DNAR notifications across all nursing care homes from 8% of notes the year prior to the study to 71% after the implementation. Anticipatory care planning documentation increased from 4% to 55%. Inappropriate deaths in hospitals of frail old residents fell from 15% to 8%; with a reduction of over 40% in inappropriate bed days in hospital in the last 8 weeks of life.
Conclusions: End of life care tools will not in themselves change practice. The implementation of these tools require 'high facilitation'. Education based within the care homes - or a 'hub' of care homes accessing the training together - plus, role-modelling anticipatory care planning was what helped to change the culture to a more appropriate palliative care approach.

PE 1.F370

End-of-life medical decisions in Acute Care for Elders Unit: A retrospective survey

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Aim: Postpone death of dying patients may result in futility and unacceptable suffering. As death

approaches some medical decisions aimed at giving comfort take into account the probability that the end of the patient's life is hasten. Prognosis and dying trajectories are less predictable in non-cancer sufferers (age-related diseases, end-stage organ failure and dementia) than in cancer ones and the former still have poorer access to optimal care. This survey describes incidence and characteristics of end-of-life medical decisions in Acute Care for Elders (ACE) Unit and their associated factors.
Methods: 97 consecutive deaths over a 1-year period are reviewed. We record age, sex, length of hospital stay, disease category (cancer/non cancer, severe dementia), end-of-life medical decisions (withdraw of artificial hydration and/or nutrition, greater alleviation of pain and/or symptoms near death, terminal sedation). Summary statistics and two-sample tests of proportion are calculated.
Results: Mean age 86 years (range 72-103), females 56 (58%), male 41, mean hospital stay 14 days (1-68), 22 patients (23%) stayed 3 days or less, 21 (22%) died from cancer, 76 from non-cancer illnesses, 44 (45%) were severely demented. In 13 patients (13%) hydration was withdrawn, in 36 (37%) greater alleviation of pain and/or symptoms was given near death, and 3 were terminally sedated. Decision to withdraw hydration was weakly associated to cancer and dementia. Greater alleviation of pain and/or symptoms was strongly associated ($p<0.05$) to cancer and hospital stay longer than 3 days. Sedation was performed in 3 cancer patients.
Conclusion: In ACE Unit greater alleviation of pain and/or symptoms near death had the highest incidence among the end-of-life decisions. People with cancer and who stayed longer in hospital had more chance to receive it. We can argue that a bias still exists against non-cancer illnesses and palliative care is not yet perceived to be an urgent care need.

PE 1.F371

Substitute decision making for end-stage dementia patients

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Aims: In geriatric palliative care, we face the problem of patients having lost their decision-making capacity. Advance directives are rarely present or sufficient to guide decisions. Therefore, substitute decision-making by relatives or legal guardians is routine. Empiric studies have questioned the ability of those decision-makers to represent the patient's actual will. Hence the questions emerge: How do they make their decisions, which considerations are decisive, and do relatives and guardians decide differently?
Methods: We chose a qualitative study design, using the Think Aloud Method which allows insights into cognitive processes. We addressed 15 relatives and 15 non-relative guardians, experienced in deciding for dementia patients. They were given two hypothetical case vignettes and had to decide about (1) a feeding tube placement and (b) a pacemaker operation in end-stage dementia patients. During the task of decision they had to verbalize all their thoughts. This was tape-recorded and analyzed according to protocol analysis.
Results: A majority of participants decided rather instinctively just after having read the cases and afterwards reflected on the reasons for their decision. Only a few pondered the pros and cons before coming to a decision. In both vignettes, the participants were not concordant in their decisions although there was a tendency towards treatment limitation. The relatives more often objected to the proposed treatment, while the guardians were more often prepared to give their consent. The guardians gave more weight to the physicians' recommendations and focused more on the patient's well-being. The relatives, on the other hand, were more heavily relying on the patients' earlier statements and presumptive wishes.
Conclusion: Substitute decision-makers have different decision-making strategies, focus on different factors and come to divergent results. Relatives tend to be more autonomy-oriented than guardians.

PE 1.F372

Person-centered communication in palliative geriatrics: A comparison of Basale Stimulation and Validiation

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Aims: The research aims at conducting a systematic comparison between two methods of communication with people with dementia - Validation and Basale Stimulation. The two methods should be embedded into scientific research. We want to support nursing staff and management to respect the subjective point of view of old persons and to make a competent choice of communication methods. The research team is committed to contributing to the well-being of chronically ill, cognitively challenged old persons.
Study design and methods: After the literature research we performed interviews with the founder and an expert for each of the two methods. Qualitative observation during lunch time and analysis of the nursing documentation in a nursing home which is familiar with the method has been performed for Basale Stimulation and is already on the way for Validation. In both homes case studies of residents will be generated with the two nursing teams and interviews with the nursing directors are planned. The findings will be analyzed by the founders of the methods and consequently the results of the two methods will be compared systematically.
Results: Intermediate results have yield to developing a set of qualitative criteria, which helps to evaluate, whether the method has been implemented sustainably in an institution. The first findings show, that Basale Stimulation and validation both are based on the theories of person-centered care (Tom Kitwood) and are compatible with each other, but they are not compatible with certain other nursing concepts or methods. They both are based on a humanistic attitude of staff, which needs to be trained and to be kept alive thoroughly. Management and its attitudes play an important role for successful implementation of the methods. There is first evidence, that each method has its strengths in specific situations and that person centered communication is best implemented in nursing homes by using a mix of different methods.

PE 1.F373

Are our older patients getting a good deal ?

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Social work recognises discrimination and disadvantaged groups and works for change. Work exists that explores why older people have unequal access to hospice and specialist palliative care services noting that this group is the single largest group of health users.
This study examines:
• The complex differences in palliative care needs of older people
• Illnesses that carry stigma especially dementia
• Attitudes towards older people, stereotyping and discrimination
• The concept of Social Death
• Older people's position and value in western society
• The issue of older people's power to influence their own care and outcome.
Specialist palliative care social work with its psychosocial brief recognises people's worth in society and the challenges they face. It has the skill to act as advocate, challenge ageism and enable older people to access their rights.
In palliative care are older people with cancer and dementia assessed and cared for in the same way as younger people with a terminal illness, noting that symptoms of brain metastases may present in a similar way to dementia.
Institutional discrimination occurs where economic planning for specialist palliative care impacts on the quality of end of life experiences for older people.
Palliative Care Social Work should promote:
• Equal access to palliative care
• Social Worker presence in palliative care teams as recommended by NICE
• Training and education.
Palliative Care Social Work challenges prejudice and assumptions which threaten the wellbeing of older people.

PE 1.F374

Raising the profile of palliative care: The poppy for medicine project in Afghanistan

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The Poppy for Medicine (P4M) Project aims to raise the political profile of morphine use for palliative care, by exploring possibilities for increasing morphine supplies for developing world markets, by producing morphine in Afghanistan.
The Poppy for Medicine technical dossier includes the technical specifications and the full economic model of the P4M system. The implications for palliative care concerns and local economic development are drawn from extensive sociological and criminological field research conducted in Afghanistan throughout 2005-2007. The Poppy for Medicine research provides a blueprint for the establishment of pilot projects for the carefully licensed cultivation of poppy crops and the production of morphine in Afghan farming communities.
The research proves that given the increasing global demand for essential poppy-based pain medicines such as morphine, Afghanistan is ideally positioned to address the substantial gap in the international market for these medicines. Exported under special trade frameworks from Afghan villages and used within the region and globally, Afghan morphine would help address the global demand for essential pain medicines. According to the International Narcotics Control Board whose mandate is to ensure an adequate supply of morphine for medical and scientific purposes, 80 percent of the world's population, including Afghanistan, face an acute shortage of essential morphine medicines.

PE 1.F376

Financing palliative care in the Netherlands

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Palliative care was and still is a main issue in the Dutch healthcare policy in the last decade. The relationships between patients, insurance companies and care providers, are described in the 'three-market-model'. This model was used to describe all aspects regarding financing palliative care in the Netherlands. The 'insurance-market' (relation 'patient- insurance company') shows that palliative care is not yet a well-defined insurable product. A major reason is the presence of three different types of insurances: The basic package described in the Healthcare Insurance Act. (HIA), supplementary packages offered by the healthcare insurance companies and the Extramural Medical Expenses Act (EMEA), a national insurance for uninsurable, long term care. From all thirty-nine healthcare insurance companies the policies for the basic and supplementary packages were examined for reimbursement of palliative care. Ten insurance companies offer no reimbursements regarding palliative care. Twenty-nine insurance companies offer reimbursement of hospicecare and/or homecare or supportive care for family caregivers. In the 'financing-market' (relation insurance company-care providers) the Dutch government developed several financial arrangements in the last decade to meet a number of bottlenecks. In this way the government presented themselves as an fourth party in the three-market-model. The government finances not only the providers of palliative care, but also departments of palliative care in the eight Comprehensive Cancer Centers, consultation teams and the seventy-one networks palliative care. In the third relation (care provider-patient) contributions patients have to pay to care providers are the main financial subjects in this part of the model.

PE 1.F377

European standards and norms for palliative care: Key areas, common definitions and consensus on basic requirements

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Aims: Palliative Care in Europe is continuously undergoing professionalization, a process which is enhanced by the European Association for Palliative Care (EAPC), and given shape by the various initiatives and research collaboratives consolidated within the EAPC. However, no common definitions, values and models of service delivery have been defined in Europe so far. The discussion is characterised by heterogeneous meanings of terms, and the basic requirements for palliative care services until now have not been consistently defined. Therefore, the EAPC has put forward a remit for a White Paper on standards and norms for palliative care in Europe.
Methods: Recommendations from relevant international committees, ministries or organisations have been examined for indications regarding the scope and the structure of the White Paper. Moreover, reports and guidelines of international hospice and palliative care organisations have been analysed in order to identify relevant aspects which have to be considered. Where information was lacking, studies and systematic reviews published in accredited journals in the field of palliative care have been drawn on. The EAPC Atlas of Palliative Care provided essential details on the status quo of palliative care delivery in Europe.
Results: Five key areas of palliative care have emerged from the analysis of the resources:
(1) definition and terminology of palliative and hospice care,
(2) common values and philosophy of palliative care,
(3) levels of palliative care,
(4) patient groups, and
(5) systems and settings.
For each key area, clear and short statements have been worked out and substantiated with background information from the literature. A draft White Paper has been developed as scientific basis for a Europe-wide consensus building process.
Conclusions: The large interest and commitment towards the consensus building process undermines the appraisal that the time is ripe for a common European approach to palliative care.

PE 1.F378

Implementation of the palliative care national strategy in the Balearic Islands

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Introduction: The Ministry of Health has promoted a Palliative Care National Strategy aiming to reach the whole population and to develop a palliative care in an efficient and equity way.
Target: The target is to develop The National Strategy in the Balearic Islands to strengthen activities, guarantee accessibility, health care, equity and to promote training and specific research.
Design and method: The multidisciplinary group has been created to analyze the critical points and to promote the strategy. The objectives, target population and activities have been defined, highlighting: objectives launched for hospital services and primary health care, enlargement of the strategy to the final stages of several chronic pathologies, medical record of the activity and the circuits among levels, computerization of a shared single medical history, elaboration of hospital training guides, training workshops, educational sessions for primary health care and promotion of grants for training and research.
Results: Among the critical points it is highlighted the lack of patients referral among the services involved, not oncologist mainly, and little training in palliative cares. Health care results will have to be evaluated in the following years. Clinical guides to use opioids, death agony and mourning are already in use. The open day has already launched with a good professional response. The computer development is being implemented, and the first workshops and educational sessions have begun with a wide participation.
Discussion: The availability of resources and professionals trained in palliative cares was a great advance in the monitoring and treatment of these patients in 1999. The implementation of the Strategy means to encourage, an opportunity of improvement and a remarkable advance to guarantee the accessibility, the equity and the palliative care development.

PE 1.F380

How early is early? Implementing WHO guidelines for palliative care in lung cancer care

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Introduction: The WHO recommends "early integration" (EI) of palliative care (PC) into cancer therapy. However, guidelines for EI are lacking. Here, the implementation of a standard operating procedure (SOP) for EI of specialized PC into lung cancer (LC) care in a comprehensive cancer centre is presented. SOP: The developing process of the SOP included
(a) the evaluation of a 2-year clinical pilot project and
(b) prospective financial calculation and successful negotiation of PC structures with major sickness funds. Specialized PC is recommended regularly for all LC patient (pts) without curative treatment option, specifically, locally advanced and metastasized LC either newly diagnosed or in relapse of the disease. Integration of PC is recommended simultaneously with start of tumour-specific therapy. This aims at
(I) improving symptom control
(II) optimizing home care,
(III) best possible preparation of pt and relatives regarding issues of a life-limiting disease and
(IV) prevention pt´s perception of being left alone after failure of tumour-specific treatment.
To offer cross-sectoral support, PC services consist of an inpatient unit, day clinic, hospital support team and specialized palliative home care team (PCT).
Discussion: Presenting an algorithm for the implementation of EI, this approach differs essentially from traditional palliative LC care by
(a) defining "red flags" for EI of PC,
(b) recommendation of PC parallel to initiation of anti-cancer therapy,
(c) offering interdisciplinary and cross-sectoral structures for optimized in- and out-pt care and
(d) clearly differentiating PC from supportive and "palliative" therapies.

PE 1.F381

Sustainable regional self-development in palliative care. Post modern health care policy strategies - Open process orientation, participation and transdisciplinary networking

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Aim: The modern age has been greatly influenced by the hope inspired by the Enlightenment and scientific thinking of being able to shape the world, to make plans and to get rid of uncertainties. But we human beings do not live and die in accordance with preordained categories and process flows. Conventional health care policies with top-down strategies thus do not correspond to complex, social realities. The qualitative study is devoted to the following research question: How can palliative care be sustainably further developed in regional health care systems and how can regional differences be appropriately integrated?
Methods: Two projects in Grisons (Switzerland) and Burgenland (Austria), whose goal was the development of a regional palliative care concept, served as case studies. Data collection: multilevel and multiperspective in both health care systems (HCS). Sample: Interviews and group discussions with 30 family carers. 11 interorganizational and interprofessional analysis workshops with 200 care professionals. Retrosp. analysis of 44 care processes in the last six month of the patient's life. 22 qualit. interviews with decision-makers in HCS. Data analysis: qualitative discourse analysis, content analysis and a meta analysis of both project processes.
Results: The key challenge of palliative care is not simply the alteration and development of the kinds of care offered. Social relationship patterns and solidarities must be strengthened and locally applied to the formal organizational structure of care provision. Organic, regional self-development processes in palliative care must be fostered.
Conclusion: Not one-sided political planning, but a cooperative, communal shaping of cultural living and thus also dying spaces must be placed in the forefront. Discourse about life and how to deal with the weakest members of society must be reflexively encouraged and conducted as transdisciplinary processes of cultural change on all levels of society.

PE 1.F382

Improving the availability and accessibility of opioids in Serbia: An update

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Background: Historically, consumption of morphine in Serbia has been one of the lowest in Europe, falling well below the regional average. One of the causes of underuse of morphine is overly restrictive national drug control policies that are barriers to opioid availability. In 2006, a health professional from Serbia was awarded an International Pain Policy Fellowship (IPPF) to learn how to evaluate national policy and work with government to remove regulatory barriers.
Aim: The aim of the IPPF is to improve patient care by improving the availability and accessibility of opioids.
Methods: The Fellow developed an Action Plan to address the following regulatory barriers:
1) Lack of availability of and access to oral opioids,
2) No recognition that opioid analgesics are absolutely necessary for the relief of pain and suffering and that it is government's obligation to ensure their adequate availability while preventing abuse and diversion, and
3) Overly restrictive laws and regulations related to opioid use.
Results: Immediate Release oral morphine was officially registered for the first time in the country's history. A National Commission for Palliative Care was established by the Ministry of Health (MoH) to which the Fellow was appointed as Vice-President. The Commission formulated the strategy recognizing:
1) opioids as absolutely necessary for pain relief/palliative care,
2) the need for opioids control policy that balance concerns about abuse and the need for medical use,
3) MoH responsibility to make opioids available to patients, and
4) MoH willingness to examine drug control policies for potential barriers.
The Commission approved the proposal written by the Fellow for improving overly restrictive laws and regulations related to opioid use.
Conclusion: Working with experts and local partners since 2006, the Fellow has made significant progress towards overcoming barriers and improving the availability and accessibility of opioids in Serbia.

PE 1.F383

Croatian declaration on palliative care, 2008 - The preliminary results

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The content of "declaration": The "declaration" is based on concept of palliative care as a part of health care and fundamental human right In Croatian government program for 2008-2011. there is a parahraph that reads: "Palliative care and hospices are to be included in the health care system (network and referral centre), the deadline being December 2008". Palliative care is for the first time introduced into the RH state budget.
Members of the family and non medical volunteers, as important factors in providing palliative care, must be recognized and supported by government policy. The Compulsory Health Insurance Act should ensure leave and remuneration for those providing care for a dying family member.
Methodology: The sample was determined by accessibility and it was non-random type.The printed „declarations" were submitted for subscription as associated signatory to different groups of potential subscribers by post and by physical contact and displayed on Internet as well. Descriptive statistic was applied. The diffusion of the text started five months ago. The study is still in progress.
Results: The majority of 699 subscribers were active

physicians (16,6%), nurses (15,7%), retired pearsons of wery different profiles (14,6%). Majority of subscribers have academic level of education (40,3%). Seven leading politicians subscribed also.
In homelad there were two group subscriptions (two societies as a whole) and one in-extenso publication in Pharmaceutical journal. Five leading personalities in world hospice and palliative care movement subscribed also. The text was published in-extenso in palliative care newsletter, Budapest.
After appearence of „declaration" we noticed significant increase of visits on web site, increased number of interviews, better comunication with leading politicians, and increased attendence on Second congress of palliative care of Croatia, October 2008.

PE 1.F384

Early integration of palliative care into lung cancer therapy by the hospital support team

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Introduction: Early integration of palliative care (PC) into the care of patients with cancer is recommended by the WHO. In our comprehensive cancer centre, a PC hospital support team (PCST) is available on request. We report about experience with the impact of our PCST on the degree of acceptance of PC integration into the care of patients with lung cancer.
Methods: Retrospective chart analysis of all lung cancer patients seen by the PCST over a 28 month period.
Results: A total of 131 lung cancer patients were visited. The number of requested consultations increased steadily over the first year and remained stable since then. As the understanding of PC structures grew within our institution, PC advice for psychosocial issues such as planning of out-patient care was increasingly requested. Moreover, the degree of inquiries to discharge the patient to the PC ward decreased. The PCST was specifically asked to improve symptom control (66%), to supply general information about PC (21%) and to clarify the indication for admission to the PC unit (8%). The interventions most often performed by the PCST were: symptom control, clarification of social issues and admittance to the PC ward. Of all consulted patients 25% died within 3 days after the first visit. The degree of PC integration measured as the number of requested consultations/lung cancer patient varied 4fold between the departments primarily concerned with lung cancer care.
Discussion: This study demonstrates that the degree of acceptance and understanding concerning competencies, values and infrastructure of PC increased steadily. Yet, contradicting the recommendations of our comprehensive cancer center, many patients were primarily seen shortly before their death and not early in the disease trajectory. Therefore the authors consider the development of a more standardised approach for the implementation of early integration to be reasonable. One measure could be the development of standard operating procedures.

PE 1.F385

Analysis of current legislative base in Ukraine on finding legislative obstacles of medical use of doctoral substances that contain narcotic and psychotropic substances for palliative patients

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Aim: Special importance and complexity of the issue of forming governmental policy on drug circulation has caused difficulties with the choice of the way of results implementation. In order to provide society's influence on governmental policy in the sphere of narcotics circulation it is necessary to consolidate the efforts of Government, NGOs, doctors, experts to improve of access to narcotic and psychotropic doctoral substances among the palliative patients of Ukraine.
Methods: Different methods we used: analysis of current Legislative Base; interviewing with doctors and patients (about 100 persons).
Results: We found more then 70 legislative obstacles of medical use of doctoral substances that contain narcotic and psychotropic substances for palliative patients.
Conclusions: On the results of the research we developed a Conception of legal circulation of narcotic and psychotropic doctoral substances (NPDS) and its integration in general of the Governmental Policy of Ukraine. Then we created of the Recommendations on necessary changes in legislation to improve of access to narcotic and psychotropic doctoral substances among the palliative patients of Ukraine and to improve availability of NPDS for medical and scientific purposes.

PE 1.F386

Developing palliative care: A top down approach

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Palliative care is usually developing as a grass root movement.
Method: In Moldova under the pressure of the local Soros Foundation palliative care was included in the national strategy. Starting from an initial needs assessment Ministry of Health nominated a task force for palliative care in 2006 and as this proved not to produce expected results several work groups (2007) were appointed to analyze specific domains like: concept paper on palliative care and regulations for palliative care services, guidelines and protocols, legislative harmonisation, access to opioid medication, education, standards, costing palliative care services.
Results: Some groups were more active. Concept paper was produced and approved by ministerial order, protocols are well on their way, cost calculation was done starting from cost for general home care services, and access to opioid medication group is getting on board relevant stakeholders. Undergraduate curriculum for nurses (62hours) was produced and included in the training. The reduced number of service providers and the challenges they face in keeping the service running prevents them playing always an active part in the process and there is concern that final products of the working groups might not be fully applicable in practice. Partially this role of keeping policy documents in the reality of palliative care has been insured by the Romanian experts. In addition study visits to Hospice Casa Sperantei were made by relevant members of the working groups. They all recognised the advantage of having a model service and set that as a priority for the country.
Conclusion: This top down approach is not unique. In the region Ukraine and Georgia are going in a similar direction. Further comparative studies would be beneficial.

PE 1.F388

Analysis of end of life choices as portrayed in the media

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in 2004 a House of Lords Select Committee examined an Assisted Dying Bill and reported to Parliament. A further Bill was introduced but defeated by 148 votes to 100 at second reading.
Recently a major media push in the UK has tried to try to get acceptance of the concept of assisted suicide both within and outside Parliament. To do this, proponents have actively sought to promote messages about palliative care and that assisted suicide is simply an extension of choice in end-of-life care. <abr> Key advocates have positioned the debate by a combination of extreme and conventional statements about 'assisted dying' to create a false debate. They include, for example:
• a call for the demented to consider seriously requesting assisted suicide to avoid being a burden to others (extreme)
• a court challenge to the Director of Public Prosecutions for assurance of non prosecution for 'assistance with suicide' prior to the event (conventional)
• a tour by Nitschke promoting his book on suicide methods (extreme)
• suicide of a 23 yr old man, quadriplegic after a rugby accident, at Dignitas (wide press debate)
• pro-euthanasia sponsored opinion polls to claim rising support (conventional)
• labelling opponents to euthanasia as motivated by religion (conventional)
• claims that 'one third of doctors kill patients with morphine' (extreme)
• claims that ceasing futile treatments is euthanasia and needs regulating (extreme, but often made)
• claims that palliative care has developed disproportionately in those countries that have legalised assisted suicide/euthanasia (conventional).
Media discussion about 'choice in end of life care' focuses on the mode of death, more than care choices to live well as death approaches. This promotes the view that death is the solution to a clinical problem, rather than more sophisticated and subtle palliative approaches.
Palliative care has been relatively poor at explaining its role and beneficial outcomes in end of life care.

PE 1.F389

Planning and funding specialist palliative care in Wales

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Aim: Following a Palliative Care Strategy report, an Implementation Board was tasked with planning and with distribution of £2 million to voluntary sector hospices in Wales (population 2.95 million).
Method: In determining a Pan-Wales formula for services, previous UK work on determining staff numbers was consulted and individual services' profiles were reviewed.
Distribution of resources was underpinned by the following set of principles of: fairness, transparency, revisability, non-discriminatory (human rights approach), clinically relevant / evidence based services, priority setting the future, avoid duplication, avoid 'boom and bust', consult key groups, cost effectively manage resources. A difficulty encountered is that stakeholders with vested interests act as lobbyists and are not always willing to look for mutually justifiable decisions.
Results: The recommendation was made that a specialist palliative care team should consist of a medical consultant, specialist nurses, physiotherapist, occupational therapist, social worker and others including chaplaincy, pharmacy etc. Palliative care specialist staff numbers were recommended as follows:
1 WTE Consultant (supported by minimum one other doctor)per 300,000 population or 20 hospice beds or 40 cancer centre beds or 850 DGH beds.
1 WTE CNS (leads team of other nurses at more junior grades) per 50,000 population or 7.5 hospice beds or 30 cancer centre beds or 300 DGH beds.
AHPs etc. numbers will need to be further calculated.
Inpatient beds or notional hospice at home ´beds´ = 1/ 15,000 population.
Funding reimburses core team costs and allows for the cost of inpatient/hospice at home beds, additional to the specialist team cost. These bed costs were estimated initially as being about £1200 / week / inpatient bed, and pro rata 1/3 for hospice at home.
Conclusion: Education, 24/7 support, collaboration between services and increased home care are key targets for the teams.

PE 1.F390

On the use of meditative life-music to accompany palliative patients on the last part of their live

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Aims: We try to give our patients the best possibilities to cope with a situation that causes a lot of fear at the last part of their live. So, we started to use meditative music and suggestive techniques as an additional tool.
Methods: A special meditative Life-music is offered to the patients directly at the bedside. The therapist is playing his instruments softly himself. It is a kind of music, that is well known in sufi-traditions to cause a therapeutic effect; mainly to reduce anxieties, giving a deep relaxation, reduction of pain and - psychologically important - giving an emotion of acceptance of the inescapable fact of the end of the material existence. We combine music and suggestive techniques, with

imaginative psychotherapy, which is known as „katathymic daydream".
Results: Some patients did not want music, as they had bad experiences with it: It caused even more symptoms of anxiety, as they learned to displace, to hide most of their feelings behind a normally inpenetrable shield of protection, which music is able to go through anyway. Those patients, who took part in our treatment, had an remarcable experience of reduction of fears, of different kinds of anxieties and could mostly better accept their situation and the proceeding to the end of life. They reported about the feeling of security, of doubtlessness, of better acceptance of the inescapable: To die free of anxiety and further psychological complications, helping them to accept and to go with the natural and mainly easy way.
Conclusions: The use of meditative life-music can be very effective to reduce different anxieties of our palliative patients and can help them to cope, to accept their inescapable situation in the stage before they really go to their final destination. It is a precious possibility to give a gain in humanity, in quality of life until the last breath.It is a very useful way to accompany them humanely on the last part of their path of life.

PE 1.F391

Religiosity and existential thoughts during severe illness - Questionnaire and pastoral care

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Method: 480 patient-handled questionnaires about belief and religiousity during severe illness and hospital admittance compared to a hospital chaplain's experience in her daily work.
Results:
Questionnaire: The results from the Survey show that, how religious the patients consider themselves to be and how much they tend to think about existential matters, is directly related to the degree of how ill they are. E.g. 58 percent of the severely ill patients state that they often think about the meaning and purpose of life, which only is true for 30 percent of the less ill patients. To the question addressing which factors have an influence on healing and recovery, the patients responded that family and friends, in addition to inner resources, are of great significance. God's influence and alternative treatment were relatively highly regarded. But here too, the patients´ conception of God differs, as it turns out that far more of the severely ill patients consider God an ally and a comforter rather than a miraculous healer. The latter is, however, a far more common conception amongst the less ill patients.
Pastoral care: The image of God that the Chaplain meets is sometimes different from the one revealed in the survey results; it can be a more negative image than what people truly wish to believe in. When people are in crisis it can be challenging to maintain a positive image of God. During these trying times, people can feel that God is above this world and above caring for them, because why else would they feel this sick? An image of a punishing God is often what comes to mind when a patient is searching for an explanation to and meaning behind their illness and suffering. Nevertheless, the Chaplain experiences that a patient's image of God can change depending on which stage of the illness the patient is in.
Conclusion: There can be a difference in the patient's perception of God depending on severeness and stage of illness.

PE 1.F392

Supportive group psychotherapy for relatives of palliative care patients: A randomized-controlled prevention study

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Aim: Many studies found that relatives of palliative care patients suffer from intense psychological distress. Psychotherapeutic interventions, however, have mainly been developed for cancer patients and only few programs exist for their relatives. Based on newer developments in behavioural therapy ("third wave"), we have developed a group intervention (8-10 participants) consisting of seven sessions (150 min each). The manual includes mindfulness meditation, meaning-centered interventions, acceptance-enhancing approaches and value-based commitments. For treatment integrity, the sessions are video-taped and led by several trained psychotherapists.
Objectives:
1. Are there positive effects of the intervention on quality of life and psychological symptoms?
2. Are these effects significant when compared to untreated controls?
Methods: The applicability and effectiveness of the group intervention are evaluated in a randomized controlled trial. The participants are relatives of inpatients of two Palliative Care Units and a radio-oncology department. Self-report questionnaires include psychological symptoms (Brief Symtpom Inventory, BSI) and quality of life (Satisfaction With Life Scale, SWLS). They are submitted at baseline, pre-/post-treatment and a follow-up after 3 months.
Results: First results (n=27, 21 female, age: 54.0±15.5) show a decrease of psychological distress during the intervention (BSI (pre) =0.93±0.43 vs. BSI (post) =0.79±0.43) and increase of distress in controls (BSI (pre) =0.41±0.24 vs. BSI (post) =1.07±0.52). In the intervention group, quality of life was constant in time (SWLS (pre)=4.32±1.68 vs. SWLS (post)=4.29±1.33) while it decreased in controls (SWLS (pre)=3.55±1.28 vs. SWLS (post)=2.48±0.46).
Conclusion: First results show positive effects of the group intervention on psychological distress and quality of life. However, these data have to be interpreted carefully because of the low number of participants. The study is still ongoing.

PE 1.F393

Involving people of diverse ethnicities in cancer research: An exploration of experiences, attitudes and barriers

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Aim: Patients from Black and Minority Ethnic (BME) groups are under-represented in cancer research, resulting in services and therapies that may be inappropriate or unable to meet their needs. This UK study aims to identify research experiences of cancer patients from BME groups; barriers to their involvement in research; and experiences and strategies of research nurses seeking to involve BME groups.
Methods: Semi-structured and narrative interviews were conducted with 22 patients with various cancer types (7 Chinese; 6 South Asian; 9 Black African/Black Caribbean) and 8 research nurses (all White British). 13 patient interviews were conducted in English and 9 in the patients' preferred language. Interviews were transcribed verbatim (following translation into English where appropriate) and analysed using thematic analysis.
Results: Most participants indicated that they were happy to take part in cancer research due principally to access to treatment, and altruism. Barriers to research participation indicated by the patients included language, culture, poor understanding of research, tendency not to talk about cancer with their family and friends, and family involvement in decision-making about research participation. Research nurses identified barriers to approaching patients such as their limited cultural awareness, ineffective interpreter services, lack of translated study materials, and patients' mistrust of research.
Conclusion: Communication barriers between patients and research nurses and between patients and their family and friends were identified in involving BME patients in cancer research. Recommendations include providing cultural awareness training for nurses, more time for nurses to establish trust with patients and their families, more effective interpreter services, translated materials, more efficient advertising of research, and support for patients to share cancer experience with others.
The study was funded by Macmillan Cancer Support.

PE 1.F395

Communicating with people with intellectual disabilities (ID) about life-limiting illness: An exploration of breaking bad news and disclosure of diagnosis and prognosis

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Aims: To explore understanding and disclosure of diagnosis and prognosis in people with ID who have cancer.
Methods: A 3-year ethnographic study of the experiences of 13 people with ID who have cancer. most of whom were terminally ill. Data collection consisted mostly of participant observation (over 250 hours).
Findings: 11 out of 13 participants were told they had cancer, but only 2 understood the full implications. Most participants were not helped to understand more about cancer. Most doctors left explanations to families and social care staff. How much people with ID understood about cancer and dying depended on cognitive ability, life experience, normal processes of denial, and how much they were told. How much people with ID were told about cancer and dying depended on power imbalance between patients and doctors/families/social care staff, skills and confidence of doctors, attitudes of social care staff and relatives, and support for social cares staff and relatives.
Conclusion: Disclosure of diagnosis and prognosis is a difficult issue that needs to be openly addressed when someone with ID has cancer. Most people with ID were protected from bad news. There were hardly any attempts to involve people with ID in decision making. People with ID need more help in understanding their diagnosis and treatment. Existing models of breaking bad news are inadequate for people with ID.

PE 1.F396

'You tell us!' - Making research accessible: The views and experiences of people with intellectual disabilities (ID) on palliative care provision

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Aims: To demonstrate, through the use of a poster, how people with ID can be involved in research around cancer, death and dying.
Methods: The poster is produced in accessible format, demonstrating how complex information can be presented in a way that is easy to understand for people with ID. The poster describes our research, which aimed to answer the following questions:
- What is it like for people with ID to have cancer?
- What is it like for people with ID to be very ill?
- What is important to people with ID who are dying?

The studies used the following methods:
- semi-structured interviews
- ethnography
- nominal group technique
- questionnaired.

Results: People with ID took part in all our studies, as participants, advisors or co-researchers. The work was written up in a thesis, which included an accessible summary, so that people with ID can understand the work we have done.
Conclusions: It is possible to listen to people with ID, even those who cannot speak. It is possible to include them in research around death and dying.

PE 1.F397

Meaning in life in patients with Amyotrophic Lateral Sclerosis (ALS)

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Aim: Loss of meaning in life (MiL) is known to be one of the main determinants of requests for hastened death. The Schedule for Meaning in Life Evaluation (SMiLE) is a newly developed instrument for the assessment of individual MiL. The objective of this study was to assess MiL in ALS patients and to compare the results with a representative sample of the German population.

Methods: 49 ALS patients were interviewed at the Munich University Hospital. In the SMiLE, respondents are asked to list 3-7 areas which are important for their MiL before rating the current level of importance and satisfaction of each area. A total SMiLE-Index (weighted satisfaction, range 0-100) is calculated. All open answers are assigned to 13 categories found in the representative survey. The results were compared to those of a representative sample (n=1,004).
Results: MiL was slightly lower in ALS-patients (SMiLE-Index=76.6±20.2) compared to the representative sample (83.3±14.8; p=.03; d=.4). The areas of MiL mentioned most often were family (82%), partnership (61%), leisure activities (53%) and friends (39%). Partnership and leisure activities were listed significantly more often by ALS patients compared to the representative sample, while work and health were mentioned significantly less often (p<.001 for each).
Conclusion: Overall MiL (SMiLE-Index) was only slightly lower in ALS-patients compared to the representative sample. Health and work were less important for MiL, while relations to significant others - especially partnership - and leisure time were listed more often. This could be due to a "response shift" in the progress of the disease, i.e. a change of internal standards as a reflection of coping strategies. Identifying ALS patients who are at risk of losing their MiL and helping them to find alternative sources of MiL may be an important step towards preventing requests for hastened death.

PE 1.F398

Cancer patients and distribution of information regarding the diagnose

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Information distribution level in cancer patients regarding their diagnoses and prognosis is very low in Georgia.
Research aim: Determination of the frequency of information distribution in cancer incurable patients regarding the true diagnose and prognosis.
Methodology: Research was based on contracts (539) signed between Palliative Care Unit, patients and their families in 2006-2007. The families were entitled to get decision on distribution of information. The level of information distribution in 193 patients hospitalized in 2006 was as follows: 16 /8,3% knew the diagnose, 27 /14% wanted to know, 150 /77.7% refused to know. The same data in 346 patients hospitalized in 2007 accordingly was: 19 /5.5%; 110 /31.8%; 217 /62.7%. The analysis shows that the number of families willing to inform the patients on diagnoses, has doubled but it didn't affect the quality of information distribution. Data on Willingness of Information Distribution Among 346 Patients Hospitalized In 2007 According the Ages:

	Under 30	30-39	40-49	50-64	65 and more	Total
Yes	3/0.9	10/2.9	28/8.1	48/13.9	35/10.1	124/35.8%
No	10/2.9	12/3.5	37/10.6	94/27.2	69/19.9	222/64.2%
Both	13/3.8	22/6.4	65/18.7	142/41.1	104/30.0	346/100.0%

The table gives the number of patients willing to be informed: under 30 - 23%; between 30-50 - 45%; over 50 - 33.7%. Analysis shows relatively high percentage of the will to be fully informed between 30-50 years, when socially activity is the highest and a person is able to make proper decisions. However, no one of these patients was informed on prognosis of the disease because of refusal of their families.
Conclusion:
1. High level of stigma on cancer diseases in Georgia is caused by lack of awareness.
2. Public demand on information distribution passes ahead of information distribution that is greatly caused by lack of training in medical personnel.
3. The age level of patient's will to be fully informed is between 30-50.

PE 1.F399

Detection of information neeed on sanitary personnel

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Introduction: From the professional perspective, it is common to find different difficulties when communicating bad news. In this aspect, the professionals' lack seems clear and the need of training on communication skills, thus broadening the sphere and not restricting the attention to only treating the physical symptoms but following the biopsychosocial model, and as a consequence, preserving the patients' autonomy principle.
Aim: To show the difficulty on communication of bad news, respecting the principle of patient autonomy and taking into account firstly patients' needs and secondly their relatives' needs.
Method: The study is based on a descriptive study based on a questionnaire conducted to health professionals from 10 specialties in the Hospital San Pedro Alcántara of Cáceres.
Results: The total number of doctors asked was 91, they came from 10 specialties. 47% considered that they knew how to communicate bad news in an efficient way and only 12% declared to have received training on communication techniques and skills. 36% would like to receive a bad new accompanied by their families. 50% would like to have all the information and decide themselves to receive or not a treatment and 44% would like to have a second opinion to get peace of mind.
Conclusions: The results show the professionals' lack of communication skills and, as a consequence, the lack of efficiency when communicating bad news. It is important to stress the professionals' wish of being informed accompanied by any relative, of decide themselves to receive or not a treatment and of looking for a second opinion. Finally, this descriptive study requires the widening and specification of its contents in a more exhaustive study on the lacks and needs when communicating bad news in our working environment, respecting the principle of patient autonomy.

PE 1.F400

Effectiveness of psychological intervention in terminally ill patients with anxiety or depression on palliative care. Preliminary results

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Terminally ill patients frequently have psychological challenges and often they experience emotional disorders.
Aims: To assess the effectiveness of some psychological interventions in terminally ill patients with anxiety and/or depression.
Method: Simple blinded, controlled, clinical survey. Patients, divided into two groups (intervention /control group), were assessed at the beginning (day0) and at the end (day15) on socialdemographic and clinical data. In the intervention group the psychological interventions have been performed for a maximum of 14 working days, using specific psychotherapeutic techniques.
Inclusion criteria: All patients in PCTs (2006-2008) with anxiety and depression (DSM IV diagnostic). Informed consent.
Analysis: Average decrease on Visual Analogic Scale (VAS) value for depression and anxiety.
Results: 34 patients were register. 11(29.72%) were randomly assigned to received intervention or not in 14 days, 8(34.78%) had disease progression, 9(39.13%) without inclusion criteria, 6(26.08%) were lost cases. For total patients (n=11): median score for depression was: Day0, VAS score: 7.91, Day15: 6.91; For anxiety was: Day 0: 5, Day 15: 4.5. In control group (n=5): median score for depression was: Day0: 7.6; Day15: 6.2. For anxiety was: Day0: 4.6; Day15: 3.4.
In intervention group (n=6): median score for depression was: Day 0: 8.2; Day 15: 7.5. For anxiety was: Day0: 5.3; Day15: 5.5.
Values for depression and anxiety have been represented for the beginning day (Day0) and the day after the intervention (Day15) distributed by group (control and intervention).
Conclusions: Limitation: small size of sample.
In the vast majority of patients, interventions have achieved improvement while the normal tendency would be increase.
PCTs counting daily with a qualified psychologist to solve complex cases in terminally ill patients with anxiety and depression. The changes are the result of the existence and effectiveness of the PCTs.

PE 1.F402

What does a palliative patient feel during bedside sonography?

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Aims: Palliative care patients with limited life expectancy, who suffer from pain and other symptoms, require a conservative but nevertheless thorough physical examination. Goal of this study was to question palliative care patients regarding bedside sonography and to place their subjective views of this procedure in the foreground.
Methods: 20 patients participated in a comprehensive 16-question interview. The interviews were recorded and later analyzed and answers categorized.
Results: None of the patients were afraid of ultrasound. Nonetheless 9 patients (45%) stated that they were afraid of the results from the examination. Most feared a worsening of their illness.15 patients (75%) felt well informed after the examination.The patients appreciated the visual findings of their illness as well as the opportunity to discuss results and fears during the examination. The majority of the patients preferred bedside sonography to other imaging based examinations that often require strenuous transportation and positioning. 13 patients (65%) thought it wise if the same physician provided the examination and treatments. The main reason for this was that a relationship and trust was already developed. All patients were convinced that the performed ultrasonic testings were important and the opportunity for bedside ultrasound in palliative care was much appreciated. 3 patients (15%) stated that they experienced uncomfortable side effects. Those pertained to pain from the pressure of the transducer, shortness of breath lying down, and the discomfort from the sticky gel. 5 patients (25%) were afraid that the physician would see less with the portable unit than with a high end unit.
Conclusion: Acceptance of bedside ultrasound ranked very high among patients. It is a modern imaging technique that facilitates communication between patient and physician and accommodates especially very ill and immobile patients.

PE 1.F403

The art of questioning - Communication with seriously ill patients

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Aim: To find out if patients in our palliative care unit are asked too many questions in light of their situation. Due to our interdisciplinary teamwork, there are many persons involved in talking to patients, caring for patients - asking patients many different questions, like "How do you feel today?", "Do you need something now?", "Did the analgesics help?", and so on. The reason for the study - reflected in my hypothesis at its beginning - was that maybe we ask too many questions. I wanted to investigate: Do we ask too many questions? Do we ask too few? Do we ask the most pertinent questions? Are there too many questions during the assessment procedure upon admission to the palliative care unit?
Methods: Physically and mentally capable patients were willing to fill in a questionnaire with seven questions regarding the amount of questions, the quality of questions, the duration of the assessment procedure, and whether there were any questions which patients would like to be asked.
Results: Over a short time span, 6 patients of our palliative care unit completed the questionnaire. The amount of patients is very small. As a first glimpse, however, it was helpful. The patients felt that the

questions were neither too many nor too few. The quality and the amount of questions were also suitable in most cases.
Conclusion: Only a few patients were able to fill in the questionnaire during the period of the small study. Despite the modest number, it was interesting to find that the amount of questions suits the needs of the patients. The duration of the assessment procedure is also declared as "acceptable". Questioning is a key aspect of communicating with patients - that is why I have chosen the title "Art of questioning" deliberately. Of course there are more studies needed regarding questioning. From my point of view, it is an interesting field which should be explored further in a deeper way.

PE 1.F404

The influence of gender and stage of disease on patients' views of cancer support groups

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Aims: There is strong evidence that support groups can benefit cancer patients. However, what patients need from groups is likely to differ with their psychological, demographic and disease characteristics. This paper considers how gender and stage of disease may influence patients' perception of benefits and disadvantages of support groups.
Methods: Patients with lung (14), colorectal (17), bladder (3) or breast cancer (18) were purposively sampled from support groups and oncology outpatient clinics (total n=52). Of these 28 were support group members, 18 were men, and the cancer of 25 could be classified as non-curable. Semi-structured interviews exploring patients' views of support groups were conducted, transcribed and subjected to thematic framework analysis.
Results: Among the findings are that patients' views of groups, irrespective of gender and stage, encompassed the same dimensions of groups as providers of information, a cancer "community" and an opportunity for comparison with others. Men predominantly focused on groups as a source of information, women were more likely to consider all dimensions. For patients with non-curable cancer, positive views of groups were more likely to be tempered by an awareness of the potential exposure to deaths, deterioration or negative information from other patients within the groups. Only those whose cancer could be classed as curable noted that groups may carry a risk of being trapped in a cancer "community" and failing to "move on".
Conclusions: This study suggests a need to tailor groups differently to men and women. It also highlights the considerable challenge in groups for patients with non-curable cancer of providing the positive benefits of mutual support, information and positive role models, while negotiating the reality of death and disease progression of many members.

PE 1.F405

Is significant psychological distress related to physical symptoms? A prospective study of patients with advanced chronic diseases

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Introduction: To achieve optimal results in the symptomatic relief of advanced chronic diseases (ACD), it is necessary to have good comprehension of the relation between different aspects of the patient and his family. It is commonly assumed that the presence of depressive, or anxious symptoms may play a role in the intensity and permanence of some physical symptoms and vice versa. However, this assumption has not been clearly sustained by supporting data.
Aim: This study had two purposes. First, we evaluated whether depression and, or anxiety were related to physical symptoms in hospitalized patients with ACD. Secondly, we assessed the screening performance of the Edmonton System Assessment Method (ESAS) for depression and anxiety, compared to the Hospital Anxiety and Depression Scale (HADS), in the same patient population.
Methods: Data were collected from 119 hospitalized patients with ACD without delirium. We compared the symptom profiles (intensity and frequency measured by the ESAS) of depressed (N: 16), non depressed (N: 102), anxious (N: 38) or non anxious (N: 80) patients classified in those labels according to the Hospital Anxiety and Depression Scale. We searched for the ideal cutoff point for depression and anxiety in the ESAS.
Results: Significantly more physical symptoms, also perceived by the patients with more intensity, were observed in anxious or depressed patients. A cut off point of 2 out of 10 in the ESAS gave sensitivity and a negative predictive value greater than 86%.
Conclusions: The ESAS was found to be a useful tool for the screening of depression and anxiety in patients with ACD (cut off point of 2 out of 10). We also found a close association between intensity and frequency of physical symptoms and depression or anxiety in these patients.
This study was partially supported by a grant from the IAHPC.

PE 1.F406

Coping with advanced cancer: An analysis of coping processes used by patients with advanced cancer in a hospice setting

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Aim: To investigate coping strategies used by patients with advanced cancer in a hospice setting, and analyze the relationship between these strategies and psychological distress.
A secondary aim is to identify if certain socio-demographic vatiables are associated with different coping strategies.
Methods: Completion of 3 self-report questionnaires as outlined below:
(a) the Ways of Coping Questionnaire (valid and reliable instrument for assessing coping processes in patients with cancer). This questionnaire identifies 8 different coping styles as follows:
(i) confrontive coping
(ii) distancing
(iii) self-controlling,
(iv) seeking social support
(v) accepting responsibility
(vi) escape-avoidance
(vii) planful problem solving
(viii) positive reappraisal
(ii) the Hospital Anxiety and Depression Scale (validated and reliable questionnaire for assessing psychologic distress in patients with general medical conditions)
(iii) A brief measure of quality of life (the 15 item EORTC-QLQ-C15-PAL). This is specifically validated for the palliative care population.
Results: This study is currently continuing to recruit participants, therefore full reults are unavailable. Identification of particular coping strategies in this patient population may allow for more targetted psycho-social interventions aimed at vulnerable patient subgroups.

PE 1.F407

Social resources in facing death and dying

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Background: Using resources is an integral part of successful coping with crises in life, such as imminent death or possible loss of a loved one. In thanatological and palliative care (pc) research, resources and their way of operation has not attracted much attention so far.
Objective: Are social resources significant and effective in the confrontation with death and dying? And how can their mode of operation be described?
Methods: Quantitative survey of 781 palliative patients, family members, and caring professionals in different pc settings. Data contains 16 parameters of social resources that are examined in relation to each other, to personal resources, and to outcome variables such as well-being, strain, and demand. Analysis was performed with non- and parametric methods, using SPSS 15.0.
Results:
1. Social resources prove to be helpful by stabilizing well-being.
2. The dichotomy of classification in social and personal resources cannot be upheld, because the inter-personal space (outer events) and the intra-personal space (inner experience) show to be interrelated and interdependent.
3. According to the data collected, variables based on the subjective perception of the person (e.g. satisfaction with social relations) are better suited for the operationalisation of social resources than variables that are based on objectives measures (e.g. size of social network).
4. Factor analysis of social resource parameters indicates five dimensions which constitute risk and protective factors:
(a) outer relatedness,
(b) inner connectedness,
(c) disturbance of the social network,
(d) network's sensitivity for change, and
(e) need for support.
5. Inner connectedness appears to be a new concept in social resources and has strong influence on strain and well-being in the pc setting.
Conclusion: These results and the theoretical analysis constitute the integrative model "Risk and Protective Factors in the Social Space", which may serve as a basis for further research.

PE 1.F408

Exploring the intangible: Sexuality and quantitative research

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Sexuality is increasingly recognised as an important issue in health care. Despite this little is known about sexuality in palliative care.
Aim: We undertook a questionnaire study to determine the importance of sexuality to Irish palliative care patients.
Methods: The questionnaire was developed using themes from a focus group study with health professionals, which explored their experience in dealing with the sexual concerns of palliative care patients. It was then piloted with a group of hospice inpatients. The final questionnaire was sent to home care and day hospice patients. The questionnaire was designed to produce predominantly quantitative data to identify if concerns relating to sexuality were important to Irish palliative care patients.
Results: The overall response rate was 13.5%. Only one respondent had previously been asked about their sexuality by a health professional, while 36% felt that they did not wish to discuss sexuality with health professionals.
Discussion: There are many possible reasons for the low response rate. These include: the sensitive nature of the subject matter; cultural/religious influence; gate-keeping; and an absence of a relationship with the principal investigator. The results of this study raise the issue of the limitations of quantitative research in exploring "qualitative" issues.
Conclusion: While sexuality is an important issue for all, care must be taken in broaching the sexual concerns of palliative care patients. The importance of building relationships and recognising the need to take a "case by case" approach when dealing with patients' sexuality concerns must be highlighted. As sexuality means different things to different people it may best be explored using qualitative methods. Further research is necessary to identify the needs of Irish palliative care patients in relation to addressing their sexual concerns. This study was not funded, but was undertaken as part of an MSc degree, through Cardiff University.

PE 1.F409

Taboo or not taboo: The changing face of sexuality in palliative care

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Sexuality is increasingly recognised as an important issue in health care. The WHO recognizes the right of all people "to the highest attainable standard of health in relation to sexuality", yet little is known about the needs of palliative care patients in relation to sexuality.
Aims: The aims of this study were threefold. Firstly, to explore the perceptions of health professionals regarding the importance of sexuality to Irish palliative care patients. Secondly, to use the themes generated to develop a postal questionnaire for patients, and thirdly to identify whether concerns relating to sexuality were important to Irish palliative care patients.
Methods: A combination of qualitative and quantitative methods was used. A focus group study

with health professionals working in palliative care was undertaken in order to explore their perceptions in relation to the importance of sexuality to Irish palliative care patients. The interviews were analysed using a method of thematic content analysis. Themes were used to develop a postal questionnaire which was sent to home care and day hospice patients.
Results: Three principal themes emerged from the focus group interviews. These were: the impact of loss and change on sexuality, the diversity of sexuality, and coming out of the dark - shedding light on sexual issues. The response rate to the questionnaire was 13.5%. Only one patient had previously been asked about their sexuality, while 36% felt that they did not wish to discuss sexuality with health professionals.
Conclusion: Further education and training would be welcomed by health professionals in relation to supporting patients with sexual concerns. While sexuality is recognised as an important issue for patients, further research is needed to identify the needs of Irish palliative care patients in relation to sexuality.
This study was not funded, but was undertaken as part of an MSc degree, through Cardiff University, Wales.

PE 1.F410

Health professionals' perceptions of the importance of sexuality to Irish palliative care patients

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Sexuality is an important aspect of life which is increasingly recognised as an important issue in the health care setting. Despite this little is known about sexuality in palliative care. The aim of this study was to explore the perceptions of health professionals regarding the importance of sexuality to Irish palliative care patients.
Methods: Three focus group interviews were undertaken, attended by a total of 20 health professionals (8, 7, and 5 respectively). Health professionals who participated included nurses, doctors, physiotherapists, and social workers. The interviews were recorded and analysed using Burnard's method of thematic content analysis.
Results: Data saturation was achieved. Three principal themes emerged from the data, which were: the impact of loss and change on sexuality, the diversity of sexuality, and coming out of the dark - shedding light on sexual issues. Participants highlighted a number of issues such as: the need for education and training to aid health professionals in dealing with patients' sexual concerns, the importance of rapport building in order to broach sexual issues, and the inhibiting effect of culture and religion on openness in relation to sexuality and discussing sexual concerns.
Conclusion: Sexuality is recognised as an important issue for Irish palliative care patients by health professionals. Further education and training in relation to supporting patients with sexual concerns would be welcomed by health professionals.

PE 1.F411

Psycho-social assessment of terminal cancer patients at the activation of palliative care unit

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Research aims: The aim of the study is the psycho-social evaluation of oncological terminal patients' condition at the intervention of the Palliative Care Unit (PCU). In this phase patients are hospitalized and PCU is activated to define a personalized palliative care program at home or in hospice by multimodal integrated modalities.
Study design and methods: We evaluated terminal patients with advanced oncological disease before hospital discharge. The evaluation was conducted with a semi-structured interview built to assess the following dimensions: state of consciousness, interactive abilities, communication, diagnosis awareness, prognosis awareness, anxiety and depression symptoms. The variables are described by percentage.
Results: From July 2004 to December 2006 we evaluated 140 terminal patients with advanced cancer (male: 82, female: 58; mean age: 71.6, range: 40-93). Regarding consciousness, 55.7% of the patients are vigilant, 26.4% conscious 17.9% confused or unconscious. Interactive abilities are spontaneous in 65% of evaluated patients, mediated by the family in 10%, following stimulation in 17.9%, absent in 7.1%. Communication is truthful in 36.4% of the patients; only 17.1% are aware about diagnosis and 3.6% about prognosis. Anxiety was individuated in 25.7% and depression in 32.9% of the patients.
Conclusion: The evaluation of psycho-social condition of terminal patients with cancer at the moment of hospital discharge indicate a state of intense vulnerability; the most critical factors seem to be diagnosis and prognosis awareness and communication between patient, health professionals and family. The PCU is activated at the final phase of a disease process marked by particular communication styles regarding cancer and prognosis. Palliative care professionals have to face mistakes and lacks of this process. These observations and the understanding of patient's emotional suffering imply several bioethical and psychological considerations in order to implement structured and personalized palliative programs.

PE 1.F412

Influence of personalized treatment plan on quality of life and psychiatric comorbidity (anxiety, depression) at patients with advanced colon cancer requiring palliative care

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Aim: Personalized medical care has been consistently proven in literature as contributing to a better adherence and quality of life for patients suffering from chronic conditions. However, limited research has investigated the role of personalized approach in ameliorating these parameters at patients with advanced incurable diseases. The scope of this paper was to investigate the possible impact of personalized care to 40 patients with advanced colon cancer requiring palliative care.
Method: 40 patients (32 M, 28 F) (mean age 64,6) with advanced colon cancer requiring palliative care were randomly assigned to a standard or to a personalized care condition, the latest implying regular (at least 2 monthly) meetings with the doctor, possibility to share treatment decisions, information about the prognosis and discussions with family members about their problems and needs. The design of the study was prospective and consisted of two successive evaluations of quality of life (SF-36 questionnaire) and anxiety and depression (HAD test).
Results: Patients pertaining to the personalized treatment approach had both superior quality of life scores ($p < 0,05$) and lower anxiety ($p < 0,01$) and depression ($p < 0,05$) than the control group. More detailed analysis showed significant differences of vitality and social functioning for subjects pertaining to the study group ($p < 0,05$), as well as a lower ratio between latent and manifest anxiety ($p < 0,01$).
Conclusion: These results argue in favor of the benefits of a personalized treatment approach for patients with advanced incurable diseases.

PE 1.F413

'Remember that I am still alive' - Living with incurable, life-threatening disease and positive and negative influences on perceived quality of life: A phenomenological study

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Aim: As a palliative nurse I noticed that a gap sometimes exists between the understanding of health care personnel and of our clients regarding quality of life. As the main aim of palliative care is, however, to contribute to people's quality of life, I felt impelled to explore the phenomenon from the patients' point of view. The purpose was to provide health care personnel with a deeper insight into this experience and empower them to become more able to support their clients.
Methods: The research approach was the Vancouver School of Doing Phenomenology, since its aim is to construct understanding by grasping the meaning of a phenomenon. Ten participants with different fatal diseases were selected through purposeful sampling. The data collection was carried out through dialogs with them, a total of fifteen dialogs. The data analysis was thematic.
Results: The study revealed that fatal illness had deep effects on the participants, who used a variety of resources to make their lives easier. Increased symptoms reminded them of the gravity of the disease and provoked existential crisis. A positive frame of mind and the feeling of having a role, had a positive influence on quality of life. An important factor was whether they received adequate social services; most of them felt that pursuing their rights was too complicated. The participants' need for 'human contact' with health care personnel was clear. A model presenting the essential structure of living with fatal disease and influences on perceived quality of life, arose from the findings, as well as a model of the 'struggle' of trying to cope when facing impending death.
Conclusion: Despite their physical burden and a life 'consisting of getting bad news,' the participants' profound need for going on with as meaningful a life as possible, and in society with others, was clear, and is reflected in the study´s overriding theme: 'Remember that I am still alive.'
Main funding: Icelandic Center for Research.

PE 1.F414

Patients' fears about cancer disease

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Aims: Cancer brings fears, concerns and uncertainty about future. Communication with patients about life-threatening illness is a real problem. Concerned doctors will continue to talk to patients in understandable language, but more research is needed about techniques to overcome patients´ fears. The aim of this study was to investigate the types of fear shown by primary care patients if they were suffering from cancer.
Methods:
Design: cross-sectional study.
Setting: primary health care.
Intervention: an anonymous self-administered questionnaire was administered to 253 primary care patients selected by consecutive sampling.
Results: Mean age was 51 years (SD 18). Sixty-four per cent were woman. Thirty-seven per cent of the patients had a univertity degree. Conversations with patients and their replies to this survey revealed that, apart from having several fears, the following four types of fears impacted especially: fear of pain (43.7%), fear of disability (20.6%), fear of death (19.4%) and fear of solitude (10.7%). There were no significant differences by gender.
Conclusions: Pain is the number one fear in primary care patients about cancer disease. The results suggest that doctors need to pay more attention to the assessment of individual patients´ fears and to avoid stereotypical views of patient fears.

PE 1.F415

Referral patterns and psychosocial needs of advanced cancer patients in an outpatient psycho-oncology counselling program

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Aims: One in three cancer patients will experience significant psychosocial distress at some point during their illness. Distress levels in advanced cancer are often more frequent, ranging from 50% to 70%. Psychosocial interventions may alleviate psychological distress and improve quality of life for patients. The goal of this presentation is to describe referral patterns and psychosocial needs of advanced cancer patients newly referred to a psycho-oncology counselling program in a comprehensive cancer facility, which is part of a larger evaluation study of this program.
Methods: All cancer outpatients newly referred to an individual psycho-oncology counselling program, over one year, were eligible. Consenting patients completed a survey of patient demographics, distress levels (Brief Symptom Inventory-18, BSI-18), coping styles (Cancer Coping Questionnaire, CCQ), and social supports (Medical Outcomes Study Social Support Survey, MOS-SSS).
Results: Of an accessible sample of 259, 145 patients completed the survey: 41/145 (28%) had advanced cancer [women 71%, mean age 57 years (SD=11),

genitourinary cancer 27%, breast cancer 24%, gastro-intestinal cancer 24%]. Most (56%) were referred by physicians or nurses, most commonly for emotional (76%) and coping (68%) difficulties. About 54% were experiencing significant distress (BSI-18 global severity index T-Score ≥ 63). The mean CCQ individual subscale was 38 (SD 7) (range 14-56, higher scores more frequent coping). The mean MOS-SSS total score was 80 (SD 16) (range 20-100, higher scores more support).
Conclusions: Advanced cancer patients newly referred for counselling have significant psychosocial distress and limited use of coping strategies. Substantive social support is important, yet may not be sufficient, to deal with the significant distress associated with advanced cancer. The need for systematic approaches for psychosocial distress screening in advanced cancer patients will be highlighted.
Funding: ACB

PE 1.F416

Body image alteration in the advanced cancer patients: Multicentric and descriptive pilot study

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Introduction: Cancer patients present changes in physical aspect and corporal integrity due to cancer treatments and natural evolution of disease. The body image can be defined as emergent feelings caused by particular perception of every person about his own body, which can determine auto-esteem, identity and interaction with environment. Body image changes (BIC) and the high psychological distress are directly related with personal dignity. Despite probability of BIC increases in advanced cancer patients, there are a few references in palliative care (PC).
Objectives:
a) prevalence of the BIC in advanced cancer patients;
b) relation between perception of self-image and objective changes of physical aspect;
c) areas affected by BIC.
Method: Survey including clinical data and semi-structured questionnarie about impact of BIC through categorical and Likert-type scales.
Patients: Advancer cancer patients who accepted to participate.
Care setting: PC teams of acute hospitals, socio-health centres and home teams.
Results: 21 advanced cancer patiets were included, 57,1% females, 62% married and mean age of 57 years. Mean of Karnofsky and Barthel index was respectively 53% and 61. Most of patients don't have psiquiatric antecedents but 86% needed psycotrop drugs. 76% of patients presented external health devices (gastric tubes, ostomies, catheter,etc.). Objectivable physic changes were observed in 70% of patients and they presented 2,7 changes/patient. 81% of patients appreciated sever BIC and 72% were worried for this reason. Affected areas were couple, sons, friends and sexuality (68, 35, 62, 80, 57% repectively). 57% of patients leaved to make usual activities caused by BIC. 67% talked about BIC but only 14% of them recieved specific help. All patients considered these questions very important and 71% though that professionals can help them. Discusion: Advanced cancer patients presented a high prevalence of BIC which affects diferent areas of environement interaction.

PE 1.F417

An investigation of the relationship between caring, levels of death anxiety and burnout syndrome among palliative care nurses

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Aim: To investigate the relationship between caring (i.e.exposure to death and dying episodes), death anxiety levels and burnout among palliative care nurses working in hospices, the community and hospitals.
Methods: A correlation research design using a cross-sectional survey was employed for this study. The purpose of the design was to correlate scores of death anxiety with those of burnout.
Data on levels of death anxiety were collected from 213 respondents using Templer's revised death anxiety scale. Data on burnout were collected using the 22 item Maslach Burnout Inventory. Data on caring were collected using a 13-item sources of pressure scale.
Results: Initial data analysis shows that there is a positive correlation between death anxiety and burnout among palliative nurses. There is no relationship between age and death anxiety or age and burnout. Nurses working in hospices showed more levels of death anxiety and burnout than nurses working in the community. Hospital nurses showed most death anxiety and burnout.
Conclusion: Certain aspects of caring seem to be instrumental in inducing death anxiety and burnout among palliative nurses. Burnout Syndrome is best understood by estimating its three components, that is, emotional exhaustion, depersonalisation and personal accomplishment. There is a need for further research to ascertain the value of social support as a mediating variable.

PE 1.F418

Patients in palliative care trials: Are they representative of the palliative care population in general?

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High attrition rates due to death and disease progression, heterogeneity of the patient population and gate-keeping by family/staff are particular challenges when recruiting patients to clinical trials in palliative care. Research however is essential to establish an evidence base for palliative medicine. For research to be meaningful it must be carried out in a representative sample of the population in which the results will be applied.
Aim: To determine whether patients recruited to palliative care studies are representative of patients seen by the palliative care clinical team.
Method: This retrospective observational study used data on all patients recruited to quantitative palliative care studies, compared with data on all new patients seen by the clinical palliative care team over a defined 12 month period (2006-2007) in a single cancer centre.
Results: 234 patients were recruited to palliative care studies. 1087 new patients were seen by the clinical palliative care team but were not entered onto a study. Patients who entered a palliative care clinical trial lived longer than those not in a study. (91.5 days and 53 days respectively, $p<0.0001$)
There were significant differences between 2 diagnosis groups; amongst patients with tumours of the male genital tract ($p< 0.05$) or tumours of the respiratory tract. ($p< 0.001$) No statistical difference was seen for age or gender.
Conclusion: The differences in survival time and diagnosis between those in a study and those not in a study may be attributed in part to specific study protocols. Differences in time to death may also represent gate-keeping in patient recruitment i.e. selection of trial patients with better performance status.
The results from this study suggest that patients recruited to clinical trials in this centre are representative of palliative care patients in general, in terms of age and gender, but some differences seen in diagnosis groups and survival time.

PE 1.F419

End of life research using published and unpublished illness narratives of motor neurone disease (MND): Methodological considerations

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Background: Illness narratives are instruments to document and relay what an illness experience means to the affected person and others close to them. Recent times have seen an increase in end of life research utilising illness narratives. These can be obtained through interviews, from autobiographies and other print media and more recently from personal web pages posted on the internet.
Aims: The study aimed to
1. Determine the feasibility of using unsolicited first person narratives as data
2. Explore the personal experience of living with MND as documented within the narratives.
Methods: The search strategy, guided by systematic review methodology, set out to gain an appreciation of the amount and type of written material available about living with the effects of MND. Ultimately 161 published and unpublished narratives written between 1968 and 2005 by people diagnosed with the illness were identified and subject to content and thematic analysis.
Results: We focus here on the challenges encountered. The steps taken to organise, access and assess huge volumes of potential material in a focused manner, to arrive at a manageable sample of narratives were complex. There were also several practical issues to be considered when using internet based material, such as the extent of the medium, the transient nature of material on the internet and the veracity of the content. Additionally, the use of unsolicited narratives raised issues relating to the need for informed consent and anonymity, as well as the need for ethical approval.
Conclusions: Unsolicited material written by people with a fatal illness can legitimately be used as research data. Methodological and ethical complexities are apparent, particularly with material located on the internet for which there is little guidance for researchers. As part of this study an algorithm was developed which takes prospective internet researchers through decision making regarding the need to seek formal research ethics approval.

PE 1.F420

An online Delphi consensus process on European standards and norms in palliative care

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Aims: The worldwide development in the field of palliative care calls for common guidelines and a consistent language in order to give information to patients and relatives and guidance to staff and stakeholders. The aim of this study is a Europe-wide consensus process on standards and norms for palliative care, more specifically on definitions and terminology, common values, and service delivery.
Methods: The scientific footing of the survey is a draft version of the White Paper based on international recommendations, standard reports and publications. Appropriate authority is provided by a remit from the board of directors of the European Association for Palliative Care. A modified two round Delphi survey has been chosen as method for the consensus building process. The board members of the national associations for hospice and palliative care in Europe have been elected as experts as they represent major stakeholders for the development of palliative care in their country. Given the geographic dimensions of such a broad international expert panel, the survey is undertaken online. The draft White Paper was translated into standardised questionnaire items with 5-point Likert scales. The paper version was pilot-tested among experts from different countries and modified in favour of a shorter questionnaire. An online version was programmed and pilot-tested with other experts in order to maximise user-friendliness.
Results: The Delphi process started in September 2008. A high commitment could be denoted on part of the experts. During the first survey round, board members from 20 different countries and 30 distinct national associations participated in the consensus process.
Conclusions: Advantages and limitations of an online Delphi survey in European countries with heterogeneous social, cultural, and technical prerequisites are discussed, as well as the exclusive use of the English language in an expert panel characterised by a broad linguistic diversity.

PE 1.F421

The involvement of terminal patients in end-of-life care research: Why and how?

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A challenge for evidence-based health care is to incorporate patients' perspectives and shared decision-making. This is especially important in end-of-life decisions, when quality of life may take precedence over life prolongation. Patients facing death are likely to have different views, preferences and values than non-

terminal patients. Therefore, it is necessary to involve terminal patients in end-of-life care research.
However, a number of ethical, practical, and methodological problems may arise. Patients can be harmed by confronting questions (e.g about euthanasia or the imminence of death). Therefore, selection of patients, duly informed about their diagnosis and prognosis, is often necessary. This has practical consequences, as it makes selection and informed consent procedures particularly laborious and delicate. Methodological problems are selection bias, lack of adequate and validated instruments for terminal patients, the possibility of response shift in the course of the (pre)terminal phase, and the loss of cognitive and physical ability in many terminal patients. Quantitative research is often hampered by the feasibility of recruitment of sufficiently large sample sizes. Qualitative methods have some advantages, such as validity (or credibility) with lower sample sizes, and the possibility to adapt the questions to the emotional capabilities of the individual participant, e.g. by letting the patients tell their story. In participant observation, the researcher has the opportunity to build a trustful relation with the patient. Furthermore, it is usually less burdensome for the patient.
Conclusion: Terminal patients are indispensable in end-of-life care research but there are several limitations, especially in case of large-scale quantitative research.

PE 1.F422

Interviewing older people about end of life issues: Experiences of qualitative research in four countries

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Background: Interviewing is frequently used for data collection in qualitative studies to gain perspectives of older people on end of life care but there is limited debate about the methodological issues faced in practice. This paper has arisen from a European study focusing on the secondary analysis of interview data derived from older people about end of life in the Netherlands, Belgium, Germany and the United Kingdom.
Aims: This paper aims to explore the range methodological issues that European researchers faced in interview studies to expand options for research practice.
Methods: Methodological issues were identified during workshops focusing on interviews with older people (n=80) from six projects which had broadly similar concerns conducted in four countries. To facilitate this, the team compared transcripts and field notes. Where necessary these were translated. Summary 'pen portraits' about interviews and accounts of methodological issues were compared.
Results: Three common methodological issues were identified:
i) The opening and closing of interviews and approach to sensitive issues; building trust and gaining the confidence of participants for discussing end of life care was evident across cultures, nevertheless it appeared easier to initiate discussion on end of life in the Netherlands as opposed to the other countries
ii) All researchers experienced other people being present: for this different management strategies were identified
iii) Emotions of interviewers and interviewees; it appeared that personal and professional backgrounds were more influential than national culture.
Conclusion: The importance of sharing research practice across cultures was recognised as useful to increase awareness of the commonality of these issues in older person end of life care, to learn from each other and to be aware of possibilities and limitations for managing such issues across national boundaries.

PE 1.F423

OPCARE9: International interdisciplinary collaboration to improve end-of-life cancer care

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OPCARE9 is an EU 7th framework coordination & support action project, with the aim of improving care in the last days of life by systematizing existing knowledge and identifying knowledge gaps. OPCARE9 provides a dynamic interface for health care providers, educatators and researchers in palliative care to meet and exchange views.
The multinational project group is interdisciplinary, with representatives from clinical professions (including medicine, nursing, pharmacy, psychology, physiotherapy and social work), and other sciences, such as epidemiology, sociology, health research, ethics and law. In addition to the participating European countries—Germany, Italy, the Netherlands, Slovenia, Sweden, Switzerland, and the UK—other regions are represented by Argentina and New Zealand.
This presentation highlights some challenging issues encountered 6 months into OPCARE9, based on discussions at the two initial project meetings. Issues which have engaged the collaborative as a whole in active discussion include:
1) questioning of established definitions and assumptions about the nature of expertise and relevant knowledge;
2) the timing, role and effects of translation from local languages to English, and how language influences the knowledge obtained;
3) how to include the neglected perspectives in this process of development, especially those which do not figure in the scientific literature; and
4) how to include the wide variety of cultures between and within countries, and utilize both consensus and diversity when systematizing knowledge.
These sometimes abstract issues inspire lively discussion and engagement in the collaborative group, but also present concrete challenges that need to be overcome in the development of specific strategies for systematic reviews of knowledge and Delphi investigations. These issues and means of dealing with them in fulfilling the aims of OPCARE9 have relevance for cross-cultural and interdisciplinary collaboration in general.

PE 1.F424

Applications of structural equation modeling in palliative care research

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Structural Equation Modeling (SEM) is a flexible statistical approach that may be used for the analysis of multivariate data to measure underlying hypothetical constructs (latent variables) and their interrelationships. SEM is a family of statistical procedures that builds on a number of techniques such as correlation, regression, analysis of variance (ANOVA), factor analysis, and path analysis to explain the relationships between measured and latent variables. SEM has many advantages over other statistical approaches; advantages include: it allows the researchers to model underlying constructs that independent variables may load upon, achieving higher levels of abstraction and understanding of the relationship between these variables; since hypothetical constructs are measured by multiple indicators where measurement error is averaged out, it allows for the use of path coefficients that are corrected for measurement error in the structural equation models; and it allows for the development, refinement and validation of theories and hypothesized relationships between variables.
The needs of terminally ill patients are numerous; they range from biomedical issues such as symptom assessment and management, to management of psychological, spiritual and social needs. The complexity of the interrelations between variables moderating palliative patients' outcomes calls for the use of strong analytical tools that may help identify them. A clear understanding of the factors underlying palliative care will allow health professionals to adequately address patients' needs and as a result improve patients' outcomes. SEM is a useful research and statistical method that has the potential for advances in this area. Despite its several benefits, it has had only limited use in palliative care research. The purpose of this presentation is to introduce SEM to palliative care researchers and provide basic procedural information for its application in palliative care.

PE 1.F425

Subject headings on major databases

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Aim: The purpose is to highlight key subject headings of particular relevance to terminal and palliative care in four major hierarchical bibliographical databases: MEDLINE, CINAHL, PsychINFO and EMBASE. In addition, the way the databases are presented in different interfaces eg via Ovid and via National Library for Health (UK) will be described.
Method: Using the mapping feature of these databases as well as the experience of the author, the results of a search on these topics in each database will be presented to ascertain key subject headings. For instance, on MEDLINE, key subject headings (MESH terms) are "terminal care", "palliative care", "terminally ill" and "hospices" (exploded where possible). "Bereavement" is also a subject heading in Medline.
Results: Each database uses slightly different subject headings that relate to terminal and palliative care. In addition, the description of subject headings can vary. For example, on CINAHL palliative care is defined as "Provision of care for relief of symptoms. Includes relief of symptoms in the terminally ill". On Medline, it is defined as "Care alleviating symptoms without curing the underlying disease".
Euthanasia is regarded as sub-category of terminal care in some databases whereas in others it is regarded as an associated or related term. The latter seems more logical.
At least two searches will illustrate the usefulness (or not) of using these subject headings when searching for particular topics.
Conclusion: It is useful to be aware of the variety of key subject headings in terminal and palliative care, especially for those new to research. When one examines them more closely, it is also debatable whether the hierarchical structure is always helpful.

PE 1.F426

Development of person centered information processing at palliative oncology outpatient units - Examples from qualitative outcome analysis

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Background: The palliative care at oncology out-patient units involves close contact between patients and health professionals over an extended period. The diversity of patient concerns, distress and information needs raises questions about how to create supportive person centered palliative care.
Aim: The aim was to describe characteristics in a narrative-based pedagogical intervention about the provision of information to patients with recurrent gastro-intestinal cancer. The intervention is based in an on-going project about information processing in palliative cancer care at an out-patient palliative oncology unit. The objectives are:
- to describe the characteristics of the intervention based in the procedures of Qualitative Outcome Analysis (a qualitatively derived theory)
- to problematize information processing in the area of palliative cancer care
- to discuss the pragmatic utility of Qualitative Outcome Analysis
- to discuss pedagogical strategies applicable for a person centered information in palliative cancer care.
Methods: The procedures of Qualitative Outcome Analysis (QOA) is used as a method for transforming qualitatively derived results rooted in the patient´s perspective and the patient´s context to the clinical setting.
Results: The concepts of "Managing existential uncertainty", "Confronting existential uncertainty" and "Living existential Certainty" were derived from previous studies and forms the basis for the QOA and the information processing described. Assessment questions and behavioral signs as indicators of outcomes to the three concepts respectively were

developed. Palliative care strategies for the intervention were finally selected.
Conclusions: The procedures of transforming the qualitatively derived data to clinically acceptable criteria is discussed. The pragmatic relevance of using QOA is considered.

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Open label study of mirtazapine for symptoms and QOL in advanced cancer

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Aim: Anorexia, anxiety, insomnia, depression, fatigue, and nausea reduce quality of life (QoL) in cancer. We studied the benefits and tolerability of mirtazapine for these symptoms in advanced cancer.
Methods: An open label 2-week (W) trial of mirtazapine with biweekly follow-up at W4 -8. Patients with poor QOL <5 (1 "poor"- 7 "excellent") and at least 1 target symptom (1 "not at all" - 4" very much") started on 15 mg at night. Doses could be increased to 30 mg at W2 depending on response (EORTC QLQ C-30) and toxicity (NCI CTCAE). A > 1 point improvement (QOL and symptoms) was a response. We measured response [mean and responders (R) relative to baseline symptoms], toxicity and dose relationship. Analysis: descriptive, Chi-square, Wilcoxon signed rank test, ANOVA.
Results: N=51 entered. Completed: W1 (34), W2 (22), W4 (12), W6 (9), W8 (7). Median age 63 (48-92); male 18/34; median ECOG: 2 (1-3). D1-7 improvement mean (SD) and R: anorexia 0.4 (1.0), p= 0.02, R=12/24; anxiety 0.4 (0.7), p<0.001, R 9/29; depression 0.3 (0.6), p=0.04, R 4/19; insomnia 0.8 (1.2), p <0.001, R =15/27; nausea 0.3 (0.9), p=0.02, R11/18. QOL improved 1.1 (1.6), p<0.001. D7-14 symptom response and QOL: plateau, or benefit was lost, appetite worsened. 10/22 had dose increased , but none further improved. Gr >3 side effects: xerostomia (5); sedation (3); constipation (3); nausea (3). Discontinued (17) v W1, v W2 did not differ at baseline for ECOG, overall health, QOL, target symptoms, and pain. 7/17 voluntarily stopped due to sedation, not by NCI criteria.
Conclusions: Mirtazapine reduced anorexia, anxiety, insomnia, nausea, depression, and QOL improved quickly. All benefits were W1, which did not further improve with time or with dose escalation. Intolerance due to sedation may be a problem greater in cancer. A placebo controlled RCT is needed to confirm response.

PE 1.F428

Evidence-based treatment in cancer: A systematic review

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Introduction: A previous review (Glare, 2004) found 21 antiemetic studies. We performed a systematic review of treatment for emesis in cancer.
Methods: A systematic review used MESH terms "nausea, vomiting, emesis and cancer, neoplasm, malignancy and treatment, drugs, medication". Pub Med, Ovid Medline and EMB Reviews Cochrane Register were searched. Trials were randomized controlled trials (RCT), prospective single arm, cohort, retrospective and case reports. Antiemetics for chemotherapy or radiation were excluded. Evidence was graded: A - RCT; B1 - single arm prospective studies; B2 - multiple drug or guideline studies for which single drug responses cannot be determined; C- cohort, retrospective studies, case reports.
Results: 70 studies included 10 RCT and 10 reviews.
Level A evidence exists for
1) metoclopramide,
2) tropisetron for metoclopramide or chlorpromazine failures,
3) tropisetron plus metoclopramide or chlorpromazine,
4) dexamethasone plus tropisetron-plus chlorpromazine or metoclopramide,
5) no response to P6 bracelets or
6) metoclopramide or ondansetron with morphine emesis.
Level B1 evidence exists for
1) chlorpromazine,
2) diphenhydramine,
3) levomepromazine,
4) perphenazine,
5) prochlorperazine,
6) thiethylperazine,
7) phenothiazines switch for treatment failure.
Level B2 evidence exists for
1) haloperidol,
2) cyclizine,
3) hyoscine butylbromide,
4) octreotide and dexamethasone for bowel obstruction.
Level C evidence exists for
1) olanzapine,
2) propofol,
3) ondansetron,
4) cannabinoids,
5) glycopyrrolate in bowel obstruction,
6) carbamazepine for leptomeningeal metastases,
7) haloperidol plus ondansetron for refractory emesis.
Conclusion: Phenothiazines or metoclopramide are antiemetics of choice. Evidence supports dose titration and switch; the addition or switch to a 5HT3 R antagonist; the addition of dexamethasone to 5HT3 receptor antagonists plus phenothiazines or metoclopramide. Antiemetic choices are based on relatively weak evidence.

PE 1.F429

Phase II trial to evaluate the efficacy and safety of oral transmucosal fentanyl citrate (OTFC) in terminally ill patients experiencing dyspnea

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Introduction: Dyspnea is a frequent symptom in palliative medicine, and may seriously affect patient quality of life.
Objective: We designed a phase II trial to evaluate the efficacy and safety of oral transmucosal fentanyl citrate (OTFC) in terminally ill cancer patients experiencing dyspnea.
Methods: Eligible criteria were: patients older than 18 years of age with satisfactory baseline cognitive function diagnosed with end-stage cancer complaining of dyspnea, admitted to the palliative care unit from January 2007 to September 2008. Inform consent was required. At the onset of dyspnea, enrolled patients were instructed to slowly dissolve the OTFC lozenge and rate their dyspnea on a 10 point visual analog scale at 15-minute intervals for 60 minutes. Respiratory rate (RR) and arterial oxygen saturation (SaO2) were recorded at similar intervals. Patients were observed for approximately 48 hours.
Results: 25 patients were found eligible. 15 patients had Lung Adenocarcinoma stage IV, 5 Colon Adenocarcinoma with lung metastases and 5 breast cancer stage IV with malignant pleural effusion. In 20 (80%) cases, patients experienced rapid relief of dyspnea as soon as five minutes. No significant adverse events were reported.
Conclusions: OTFC appears to be safe and effective for dyspnea in terminally ill cancer patients. This findings are promising and merit further research.

PE 1.F430

Making it happen: Improving our care and services

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Research shows that although the majority of people report that they would choose to die in their home, only a minority of patients achieve this wish; improving choice at end of life analysis suggests that home deaths rose from 19% in 2005-6 to 25% during 2006-7*. In January 2007 Sue Ryder Care's Leckhampton Court Hospice piloted a 'Hospice at Home' programme of care for palliative patients whose preferred place of death was at home, this was a natural extension of the care already offered by Leckhampton Court. This paper reflects on the reconfiguration and development of the Hospice at Home Service, drawing on the learning from the pilot service evaluation, and feedback from service users.
The Hospice at Home service aims to prevent patients nearing the end of their life from being admitted to the hospice or hospital wherever possible. It provides patients at the later stages of their illness to access the same high level of care and support that they would receive in the hospice or hospital in their own home, remaining close to family and friends, in familiar and reassuring surroundings. It also provides much needed respite for carers at this difficult time. As a community based service Hospice at Home is jointly co-ordinated from within Leckhampton Court's Day Hospice. It provides the care and services for patients with specialist palliative care needs in a responsive and flexible manner.
This paper reflects on the current model of hospice at home, the challenges encountered and lessons learnt in reconfiguring the service to increase its sustainability and quality of patient care.
*Figures quoted from the King's Fund: Improving Choice at End of Life - Rachael Addicot & Steve Dewar April 2008

PE 1.F431

Does the use of bedside sonography influence the clinical management of palliative care patients?

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Introduction: Palliative Care patients are severely ill and suffer from multiple complaints. Optimal symptom control is essential, but unnecessary diagnostic procedures should be avoided. The use of bedside sonography in a Palliative Care Unit was the aim of this study.
Methods: From January 2004 till September 2006, 478 US examinations were performed. Indications for US were: dyspnoea (152 pat., 31,8%), basic staging (133 pat., 28,2%), abdominal discomfort (95 pat., 19,9%), follow up (42 pat., 8,8%), central venous line (18 pat., 3,8%) and others (36 pat.,.7,5%).
Results: In 245 pat. (51,3%) the clinical management was influenced by sonography. US guided interventions (149 cases, 31,2%) incuded:
Drainage of
- pleural effusions 64 pat. (13,4%)
- ascites 32 pat. (6,7%)
- abscesses 7 pat. (1,4%)
Central venous line: 18 pat. (11,4%)
Others: 9 pat. (1,8%).
In 163 pat. (38,1%) treatment was changed due to the US results. In 7 patients (1 ,4%) therapy was abandoned because of the US findings.
Conclusion: Bedside sonography influences the clinical management of palliative care patients: The possibility of US guided drainage of pleural effusions or ascites attributes to an optimal symptom control. The diagnosis f.e. of pneumonia, bowel obstruction or congestive cardiac failure based on ultrasound results leads to changes in medical treatment.

PE 1.F432

Is symptom burden really a good criteria to discharge patients from palliative care units?

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Research aims: Pphysical symptoms and psychological distress are frequent admission criteria in palliative care units. The aim of this study was to detect symptomatic improvement before discharge of patients from the palliative care.
Study design and methods: Retrospective chart review of all patients with an advanced oncological disease hospitalised in the palliative care units of the University Hospitals of Geneva from June to August 2008 who were discharged home or to a long term care unit. Exclusion criteria was inability to complete Edmonton Symptom Assessment System at admission or at discharge.
Results: 25 patients were included (13 men, mean age: 74.44±7.75). Cancer diagnosis was: respiratory (n: 11), gastro-intestinal (n: 8), urological (n: 4). Ten patients were admitted from an acute care unit and 15 from home. Reasons for admission were decrease of general condition (n: 13) and poor symptom control (22). Twelve patients were transferred to long term care units, 1 to a nursing home and 12 returned home. Mean (±SD) intensity of symptoms at admission (A) and discharge (D) was: Pain: A 2.8±3.0, B 1.9±2.0; Nausea: A 1.1±2.4, B 1.1±2.6; Dyspnea: A 1.7±2.3, B 2.1±2.6; Fatigue: A 4.4±3.6, B 3.8±3.4; Drowsiness: A 3.3±3.3, B 3.5±2.9; Appetite: A 4.3±3.3, B 3.8±3.4; Anxiety: A 3.3±3.5, B 2.7±2.5; Depression: A 3.6±2.8, B 3.1±3.0; Well-being: A 3.7±2.5, B 4.1±2.3;Total: A 28.2±15.6, B 26.4±14.8. P was>0.05 between intensity of symptom at admission and at discharge.
Conclusion: Symptom management is crucial in palliative care; however, some patients are still able to

leave the palliative care unit without improvement of their symptoms. Other aspects, particularly psycho-social and not mentioned at admission, appear fundamental criteria to permit discharge of patients with an advanced oncological disease.

PE 1.F433

Should we use systematic screening for depression in palliative care? A systematic literature review

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Depression in the most common psychiatric illness in patients with advanced cancer and it is known to reduce quality of life (Block 2000). In clinical practice it's often assumed that depression affect the presence and intensity of physical symptoms. (Ciaramella 2001; Teunissen, de Graeff et al. 2007). These physical symptoms (pain, sleep disturbances, anorexia) can be improved by an adequate treatment of depression (F. Steifel 2001).
Aim: The aim of this review is to identify all the known literature on systematic screening of depression in palliative care, and its benefits.
Methodology: Relevant research articles were identified and retrieved from a systematic search of computerized database (Medline, BDSP). All literature searches span from December 1997 to December 2007. The electronic database was searched by exploding the following Medical Subject Heading search terms "depression" and combining with "advanced cancer". Three reviewers independently assess initial data from this first listing.
After the first author graded each paper according to studies' quality of evidence. Because studies were heterogeneous, we have not attempted to perform formal statistical data synthesis or meta-analysis. Instead we present and discuss each individual study.
Results: The searches yielded 365 references and following the reading of abstract 60 papers were obtained. From those 60 articles, 17 were excluded. Forty-three remained articles were included in our systematic review.
Conclusion: This systematic review highlights the need for a systematic screening for the depression. It is a "silent" symptom, and very often the clinical feature is neglected by the caregivers and physicians as a normal sadness facing a disease threatening the life. A systematic screening can improve the early treatment, including the non-pharmaceutical approach, and arise the team awareness about the depression.

PE 1.F434

Withdrawn

PE 1.F435

Propofol for terminal sedation in palliative care - A systematic review

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Aim: Sedation is used in the care of the dying to alleviate severe and distressing symptoms when other means fail. It can be used in an attempt to control physical symptoms such as pain and dyspnoea, as well as for spiritual and psychological symptoms. In cases where standard treatments fail, the anaesthetic agent Propofol has been used as an alternative. We undertook a systematic review of published evidence of the effectiveness of propofol for terminal sedation.
Methods:
Inclusions: Prospective or retrospective trials (controlled or uncontrolled) or case series of propofol for sedation in advanced incurable disease in either generalist setting or specialist palliative care units.
Exclusions: Use in anaesthetic or intensivist settings (e.g. intensive care units); Identification of relevant studies: Using the search terms: [Hospice Care/ OR Terminal Care/ OR Palliative Care/ OR palliative.mp] AND [Propofol/].
Studies were identified using a detailed search strategy from a number of electronic databases: Embase (1988-2005); Medline (1966-2005) Cinahl (1982-2005),Cancerlit (1962- 2005) The Cochrane Database of Systematic Reviews 2005 Issue 4. Hand searches of a number of palliative care journals were also undertaken (Palliative Medicine, Journal of Pain and Symptom Management, Progress in Palliative Care, Journal of Palliative Care, Journal of Palliative Medicine) . No restriction was placed on the language of the original article.
Results: Four papers - all case series or case reports - reporting generally favourable reports of the use of Propofol as sedation for intractable symptoms in the last days of life especially when one or more other drugs have failed.
Conclusion: Since these four papers are essentially hypothesis-generating, it will be necessary to design and undertake a robust controlled clinical trial of Propofol versus accepted best current practice to determine the effectiveness of Propofol for terminal sedation.

PE 1.F437

A retrospective review of the use of octreotide in an acute hospital palliative medicine referral service

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Octreotide is a synthethic analogue of somatostatin. There is a paucity of published data on the doses of octreotide used in day-to-day clinical practice in patients with advanced malignancy. The aim of this audit is to study the indication, dose ranges and effectiveness of octreotide in the setting of intestinal obstruction, fistulae, gastrointestinal bleeding and diarrhoea.
A retrospective audit of all patients referred to the Palliative Care Medical Service at UCHG from January 2007 to March 2007 was performed.
Data was obtained for 121/147 patients (82%). 14 were on octreotide (11%). The indication for 8 patients (57%) was bowel obstruction. The average starting dose was 1250mcg/24hr in a continuous subcutaneous infusion (CSCI) which in most patients increased over time to a maximum of 3000mg/24hr CSCI. Results of data recording use of anti-emetics, nausea scores, number of vomits, NG tube use and pain scores are shown in table format, and showed a reduction in symptoms with use of octreotide over time. 2 patients stayed on octreotide long-term. 3 patients (37.5%) experienced steatorrhoea. Of the 3 patients (21%) who were treated with octreotide for diarrhoea (chemotherapy and radiotherapy-induced), the average starting dose was 1000mg/24hr CSCI. A reduction over time of number of bowel motions, nausea and anti-diarrhoeal use was shown. No patient stayed on octreotide long-term. One patient experienced steatorrhoea. Data was also recorded for 3 patients who received octreotide for management of fistulae and for haematemesis.
Octreotide was shown to be useful in the management of bowel obstruction, diarrhoea and other conditions. In many cases effective symptom control was only achieved using higher doses than that stated in the current literature. This retrospective audit goes some way towards addressing the issue of dosage and may aid further study in this under-researched area.

PE 1.F438

Naproxen for neoplastic fever: A simple treatment for a distressing syndrome

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Introduction: Neoplastic fever is a frequently under-diagnosed paraneoplastic syndrome that affects around 15% of cancer patients. Its diagnosis is based on the exclusion of other causes of fever and it can be managed effectively with non-steroidal anti-inflammatory drugs specially naproxen. We report a case of renal transitional cell carcinoma associated with neoplastic fever.
Case: A 37 years old female was first diagnosed to have left renal pelvis transitional cell carcinoma in Dec 2007. She had a metastatic disease to the lungs and liver at presentation and responded poorly to two regimens of palliative chemotherapy. Nine months after diagnosis she was hospitalized with an ECOG performance status of three, fever, sweating, fatigue and generalized bony aches. Clinical examination and radiological investigations failed to locate a source of infection and other causes of fever were excluded. The patient received meropenem then piperacillin+tazobactam empirically and maintained on regular acetaminophen without response. In addition, fever did not respond to indomethacin and responded to dexamethazone for only 2 days. After 2 weeks of hospitalization, the palliative care consultation team started her on naproxen 250 mg twice daily. The patient experienced a dramatic response with complete lysis of fever and control of sweating, bony aches and fatigue. The next day, she was discharged home with an ECOG performance status of one.
Conclusion: Overlooking neoplastic fever may lead to unnecessary hospitalization, investigations and treatment that, in addition to uncontrolled symptoms, can result in a significant suffering. In the palliative care setting, neoplastic fever should be considered in febrile advanced cancer patients after exclusion of other causes. Unless otherwise contraindicated, naproxen can relieve distressing symptoms and avoid unnecessary interventions in patients with neoplastic fever.

PE 1.F439

Application of essential oils in palliative care

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Aims: Aroma therapy is defined as an alternative medicinal treatment using essential oils to support well being and health, to recreate relaxation, to release energy and to re-establish balance of body and mind and therefore it is used in palliative care to treat several symptoms.
Methods: Essential oils are applied transdermal, nasal, rectal and according to this there is an effect on function of several organs and in addition to this, by sense of smell, the limbic system and further the autonomic nervous system is influenced. In treatment with essential oils several guidelines are to be considered. It is necessary to use only diluted oils and to test compatibility before application. Only substances of high quality should be applied.
Results: In palliative care special results can be reached by using relaxing, fear and pain releasing and fetidness reducing oils. The effectiveness is evidenced in several clinical trials. In the context of palliative treatment we prefer to use essential oils of citric fruits, lavendel, rosemary, bergamod, rose, petit grain, fennel, anise, peppermint, melissa, cajeput etc.
Conclusion: Therefore treatment with essential oils is a good complementary kind of therapy additional to clinical medicine.

PE 1.F442

Constipation in patients with advanced cancer: An action research approach to management

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Constipation in cancer and palliative care is frequent and has a profound adverse effect on patients´ lives. Semi-structured interviews and focus groups revealed that poor management of constipation was due to poor knowledge and ambivalent attitudes of health care professionals (HCPs), inadequate patient education and a lack of a concordant approach. Patients described feeling abandoned, their condition trivialised and many suffered distress and embarrassment. The researchers postulated that constipation management would be improved by redressing the educational needs of HCPs, imparting knowledge to patients and working to develop a partnership approach.
Using a collaborative multidisciplinary action research methodology, HCPs empirically explored reducing constipation by improving patient understanding, optimising laxative regimens and improving concordance through the development of a nurse-led clinic.
A cohort of 29 (9m/20f) patients with severe/intractable constipation was recruited to a clinic utilising a patient-focused, education-based management strategy.
Laxative samples and pictorial representations were used as educational aids. Individuals' laxative regimens were reviewed and found to be sub optimal in dose, frequency of use or both. Listening to patients concerns, addressing misconceptions and providing a physical examination were reported as being 'help at last'.
Following attendance there was an immediate

improvement in bowel function in all patients who became more autonomous and concordant with their treatment regimens. All patients reported having a better understanding about the causes and consequences of constipation and understanding the role and use of laxatives. Clinic attendance was minimised by using telephone follow-up that was found to be beneficial and less burdensome.
This study highlights the importance and benefits of adopting a concordant approach and paying attention to detail when managing constipation in patients with cancer.

PE 1.F443

What is the current evidence in management of dyspnoea in advanced disease?

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Background: Dyspnoea is one of the most common and distressing symptoms in advanced malignant and non-malignant diseases. The management isn't always successful although research is increasing over the last few years.
Aim: To demonstrate the current evidence of non-pharmacological and pharmacological measurements in the relief of dyspnoea in advanced malignant and non-malignant diseases.
Method: Review of the literature and current practice in palliative care (including two own Cochrane reviews).
Result: Management of dyspnoea comprises both non-pharmacological and pharmacological interventions. There is good evidence for pulmonary rehabilitation in COPD patients and there seems to be also good for neuromuscular electrical stimulation and chest wall vibration in COPD patients. Evidence for the use of walking aids and breathing training is moderate. The evidence for various other interventions such as acupuncture and music can not be judged due to limited numbers of studies. For pharmacological measures, there is good evidence for oral and parenteral opioids but not for the nebulized route. Although benzodiazepines are widely used there is currently no evidence to support their use for the relief of dyspnoea. Regarding the use of oxygen, no consistent beneficial effect could be shown but some patients do feel better after oxygen application. Other drugs such as phenothiazines, nebulized furosemide, and antidepressants have been tested but there is not enough data to judge the evidence at this time.
Conclusion: There overall evidence for the treatment of dyspnoea is limited. Further well conducted trials are needed in this area to reduce the burden of this common and distressing symptom.

PE 1.F444

Outpatient setting for abdominal paracentesis of malignant ascites

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Aim: The management of drug-therapy resistant malignant ascites is a significant challenge in palliative care. Abdominal paracentesis is an accepted method to palliate symptoms like abdominal pain, shortness of breath, or early satiety (1). Often these patients were hospitalized solely because physicians suspect complications (2). Using modern paracentesis needles at least following abdominal paracentesises are possible to provide in an outpatient setting.
Methods: 23 Patients with an expected ascites volume of more than 2 l were included. An earlier ultrasound guided ascites paracentesis in medical practice or palliative care unit was optional desired. Outpatient punction was operated at the same point of the earlier punction or at the typical punction point in left lower abdomen. After skin desinfektion a punction set with a one-way trocar and a perforated catheter set was used.
Results: Abdominal paracentesis could be provided to patients in medical practice as well as at home or in hospice. The Retreatment was easy due to the mark of the former punction but also not pretreated patients could obtain abdominal paracentesis. Serious complications were not seen and in several cases antineoplastic agents could be administered after paracentesis.
Conclusion: To avoid unnessarary transports abdominal paracentesis can be provided to patients in a safe outpatient setting.

PE 1.F445

Anaemia and other predictors of fatigue among patients on palliative therapy for advanced cancer

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Aim: Predictors of fatigue among cancer patients on palliative treatment are ill defined. The role of anaemia and other predictors of fatigue was studied in cancer patients on palliative treatment.
Methods: A cohort of 128 consecutive patients (61 males and 67 women, mean age 63.6 yrs; range 36-85) was interviewed using the Edmonton Symptom Assessment System (ESAS) questionnaire, with 11 items describing cancer-related symptoms in VAS scale. Routine haematological samples were analysed at the time of interview. Both univariate- and multivariate analysis was used to assess the independent predictors of fatigue.
Results: Of the 10 symptoms recorded, fatigue was the single most frequent one, reported by 91.3% of the patients, followed by pain (74.8%), sleeplessness (78.0%) and depression (74.2%). Anaemia was a significant determinant of fatigue (p=0.040)(OR=5.09; 95%CI 1.013-25.647). Of the symptoms recorded, fatigue was significantly associated with depression (p=0.035), loss of appetite (p=0.016), anxiety (p=0.050), and sleeplessness (p=0.016). Total wellbeing was negatively associated with fatigue (OR=0.48, 95%CI 0.011-0.020)(p=0.0001). In multivariate analysis, anaemia was the most powerful independent predictor for fatigue, with OR=38.27 (95%CI 2.62-559.19)(p=0.008), followed by sleeplessness (OR=14.06 95% CI 1.44-137.02 p=0.023) and loss of appetite (OR=10.30 95% CI 1.04-101.10, p=0.045). Fatigue was unrelated to sex and age, as well as to the type of cancer and the treatment category.
Conclusion: Fatigue was extremely common among cancer patients on palliative care. The single most powerful independent explanatory factor of fatigue was anaemia, implicating a need for interventional studies.

PE 1.F446

Nutrition care - A forgotten aspect of palliative care

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Without food, life is not possible and some form of nourishment should be provided to every patient who is capable of eating. The continued receipt of food and water is fundamental to life, and to deny an individual these essential substrates seems morally indefensible. To observe the anorexia, fatigue, wasting, debilitation-the-cachexia of the patients with advanced cancer is a dishearting experience for every one.
Food is more than nutrition and plays a very important role in maintaining hope and offering some means of comfort to patients. Adequate nutritional intake is often difficult, if not impossible, for the person with a terminal illness. Patients, families, and caregivers struggle to continue providing food and fluids in the face of declining ability and interest.
During the year of 2006, total 123 patients were referred to dietitian for dietary support and advice during their palliation. It is shocking that >10% patients were died or the appointment was cancelled due to poor health. Most of patients were referred to dietitian at the last stage of life/ disease. The understanding and awareness about the role of nutrition in palliative care is very low among clinicians. Most of these patients were referred to dietitian on the request of the family. No process of nutritional screening exists and the importance of nutrition in the Palliative phase is forgotten.
Through nutritional screening and assessment is, therefore, paramount to identify patients who are malnourished or at risk of malnutrition in order to provide optimal nutritional care to minimize effects malnutrition, cachexia and fatigue.
Finding and treating nutrition problems early may help the patient gain or maintain weight, improve the patient´s response to therapy, improved quality of life, reduce complications of treatment and more satisfaction among patients and carer.

PE 1.F447

Overcoming obstacles to conducting trials in the context of palliative care: An exploratory phase II cluster randomised trial to investigate the effectiveness of the 'Macmillan Approach to Weight loss and Eating difficulties' (MAWE)

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Background: Weight loss and anorexia are symptoms experienced by up to 80% of people with advanced cancer. These symptoms can be distressing for both patients and their carers. Effective management of this weight and eating related distress is likely to improve quality of life and could reduce demands on supportive care services.
The Macmillan Weight and Eating Studies (2000-2008) have developed the first complex psychosocial intervention for weight and eating related distress in people with advanced cancer and their carers: The Macmillan Approach to Weight and Eating (MAWE).
Aim: This paper is about a Phase II trial of MAWE. It presents
i) challenges of conducting the exploratory trial in the context of palliative care, and how these were successfully addressed, and
ii) evidence that MAWE can help patients and their carers live with advanced cancer.
Methods: The Phase II trial, conducted in the UK in 2006-2007, was of cluster randomised design. It used mixed methods to compare an intervention group (n=25), who were supported by MAWE trained Clinical Nurse Specialists (CNSs); with a group who received standard care (n=25), the Control Group. The trial was a feasibility study. Its purpose was to test
i) recruitment and data collection process,
ii) the deliverability and acceptability of MAWE, and
iii) the efficacy of MAWE.
Results: The study achieved its recruitment target, data collection tools were acceptable to participants, and CNSs were able to deliver MAWE in the context of their everyday practice. Contamination of the MAWE group prior to baseline data collection was problematic. However, both quantitative and qualitative data analysis support the proposition that MAWE can help patients and their carers live with advanced cancer.
Conclusion: The evidence collated supports the argument that a RCT of MAWE is warranted, but it should be of a revised design.
Funding body: Macmillan Cancer Support, UK

PE 1.F448

Role of cortico-steroids in palliative care

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Introduction: Patients referred to the Palliative Care Clinic have advancing cancer, with a plethora of symptoms, needing rapid relief. Cortico-steroids are used regularly . Some unusual indications are presented in this paper.
Materials and methods: All case papers of patients treated at the Palliative care Unit since January 2008 were retrospectively analysed for use of corticosteroids, indications, dose, time-frame and efficacy.
Results: 1350 consecutive case files were analysed. Oral Dexamethasone was the only steroid used in 215 patients (16%); maximum 24 mg per day, Unit policy ; no emergencies. The most common indication was peritumoral oedema In the Head & Neck area, where symptoms are especially distressing ,it was found very effective in 177 patients; a low dose was used for upto 4 months. For brain and spinal mets., a high dose was used in 52 patients for 7-10 days and a dose of 2-4 mg was maintained, even in diabetics and hypertensives. Found very useful for neuropathic pain, with conventional medications, in 6 patients. For breathlessness,found effective for 18 patients. With anorexia and cachexia, improved apetite and well being in 12 patients. 80% of the patients reported improvement in these indications, when used primarily for other symptoms. 1 patient with pericardial effusion and 21 patients with lymphoedema were relieved. Time of administration- By convention, steroids are reported to ineffective after 4-6 weeks; our patients were maintained, with minimum side effects, for upto 4 months in adults. Where high dose was given, it was tapered within 7-10 days and a low dose maintenance was continued The indications are much more in paediatric tumours.
Conclusions: Where the armamentarium of

medications are not complete, especially in developing countries, certain innovations are necessary. These results show how certain innovations can help alleviate suffering for many patients with advancing cancer.

PE 1.F449

The management of cough in palliative care

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Aim: Evidence suggests that chronic cough (>8 weeks) is a common, debilitating condition in about 37% of patients with advanced cancer. In the acute setting, the role of cough is to expel foreign material and secretions, and to protect the airway. In the chronic setting, coughing often serves no protective function. Instead it reduces quality of life through interference with breathing, speaking, sleeping, eating and social activity. In the palliative setting, it may not be possible to identify a reversible cause of chronic cough, and hence treatment must focus on symptom control often in the form of pharmacotherapy. This poster presents the results of a systematic review of the evidence for effective management of chronic cough in the palliative setting. From this review, guidelines are proposed for the management of cough and suggestions for further research are proposed.
Methods: Studies in humans with life-limiting illness and chronic cough were identified using both electronic and hand-searching methods. Standard data extraction methods were used to assess the quality of each paper and to establish whether it should be included in the systematic review. The data from those papers accepted into the review was then collated.
Results: Although there is literature on the management of chronic cough in palliative patients, so far very little high quality evidence has been identified.
Conclusions: It may not be possible to propose evidence-based guidelines for the management of chronic cough in the palliative care setting at the present time. However, consensus guidelines are proposed and areas in need of further research are identified.

PE 1.F450

Inflammation and nutritional intake: Are they really needed to classify cancer cachexia? A systematic literature review

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Aim: To guide clinical decisions or trials in palliative cancer care we systematically reviewed inflammation **(I)**, reduced food intake **(FI)**, symptoms **(S)**, insulin resistance **(IR)**, and other factors related to involuntary weight loss **(wl)** in advanced cancer.
Methods: Two search strings (cachexia/cancer) were applied in MEDLINE, Cochrane, EMBASE, PsycINFO, and CinAhl, (1976-2007). Citations, abstracts and papers were searched by 3 investigators (interrater-reliability 93-95%) for inclusion criteria: original work, English/German, for each factor either a group comparison **(gc)** of defined wl groups or correlations **(cor)** inside a wl group.
Results: Of 14'344 citations, 1275 abstracts and 585 papers reviewed, 82 papers were included, representing 6144 cancer patients (40-50% gastrointestinal, 10-20% lung). Different definitions of wl compared to pre-illness weight (n=48) or % wl during a specified time period (n=34: [10% n=19, 5%: n=15]) were used. The results of the Factors **I, FI, S, IR** include:

Factor	Patients	Studies	(gc / cor)	pos.	neg.
I: CRP	722	8	(5/3)	6 (3 gc, 3 cor)	2 (2 gc)
I: Cytokines	581	11	(9/2)	6 (5 gc, 1 cor)	5 (4gc, 1cor)
FI: Energy	1322	9	(6/3)	5 (3gc, 2 cor)	4 (3gc, 1cor)
FI: Protein	557	5	(5/0)	3 (3gc)	2 (2gc)
S: Anorexia	774	5	(4/1)	4 (3gc, 1cor)	1 (1cor)
S: Fatigue	219	2	(2/0)	1 (1gc)	1 (1gc)
IR: Insulin	172	6	(6/0)	3 (3gc)	3 (3gc)

Body Composition (studies: n=8), Resting Energy Expenditure (n=11), eating-regulating hormones (Leptin/Ghrelin) (n=9), catabolic/anabolic factors (PIF, Testosterone) (n=7), and other (n=6) yielded variable results. Only five papers applied exploratory multivariate analysis with few selected and different factors.
Conclusion: For clinical decisions CRP and anorexia seem valuable. To classify cachexia a combination of factors is required. Multivariate analysis of these factors and prospective testing of such a classification system suggesting distinguishable phenotypes is needed.

PE 1.F451

Biliary stents in malignant obstructive jaundice: Retrospective analysis about outcomes and complications

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Most patients with malignant obstructive jaundice have inoperable disease at presentation. Miniature intraductal endoscope is having an increasingly important role in the non surgical treatment of biliary tree diseases and in the palliation of obstructive jaundice. Incidence rates of complications vary widely, depending upon the definition adopted, the methods of data collection, and the case mix. Retrospective surveys underestimate the frequency of adverse events. However, even prospective surveys are prone to induce biases if the modality of data collection does not use strict criteria. Prospective surveys from single referral centres ensure the highest accuracy, but are unlikely to be representative about the frequency and severity of unfavourable events. Prospective metacentre studies reflect more reliably the effectiveness and safety of the procedure.
Aim: This paper presents a review of all patients who underwent biliary disobstruction with the aim to identify common characteristics in patients and indicators for a favourable outcome.
Method: We examined 55 charts of patients who died from 2002 to 2007 in our institution (Institute of Oncology of Southern Switzerland), and that underwent biliary stenting through percutaneous transhepatic cholangiography or endoscopic retrograde cholangiopancreatography. The stenting procedure in this sample was performed by different physician or teams.
Results: 25 patients underwent more than one procedure for the failure of their first intervention or relapse of obstruction. Resolution of jaundice was obtained at the first intervention in 41 patients. Overall we reported 58 events of infection (6 cases of sepsis and 4 cases of death for sepsis), 10 occlusions, 4 dislocations and some others complications.
Conclusions: The operating teams have been confronted with the results of this retrospective analysis. There is growing agreement that it is mandatory to elaborate a strategy in addressing this issue in our institution.

PE 1.F452

Less is more: The management of agitation and delirium In the palliative care setting

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Aims: Agitation is a common symptom in Palliative Care, particularly at the end of life. There has been controversy surrounding the use of sedative drugs in the dying phase. This audit aimed to measure the management of agitation and delirium against regional guidelines.
Methods: A prospective audit of patients deemed to have agitation and/or delirium across hospital, community and specialist palliative care unit settings in the Merseyside and Cheshire cancer network over a 2 month period. Data were collected on the initial assessment and drug management of agitation and delirium and follow up data over a one week period. We report on the drug doses used.
Results: 69 patients were included in the audit. 44 patients died during the study period and the Liverpool Care Pathway for the care of dying patients was used in the majority of cases. The first-line drug used for agitation was midazolam with the median regular dose used to treat agitation being 10mg over 24 hours (range 2.5-60mg). The median as required dose of midazolam was 2.5mg prn (range 2.5- 10mg prn). The most commonly used second-line drug in the management of agitation was levomepromazine and the median regular dose was 25mg over 24 hours (range 6.25mg-200mg). Other drugs used included clonazepam (range 1-3mg over 24hours), haloperidol (range 1.5-5mg over 24 hours) and one patient with refractory agitation required phenobarbitone 600mg over 24 hours. At 7 days there were no patients whose symptoms could be described as uncontrolled.
Conclusion: This audit highlights the fact that agitation and delirium are commonly encountered symptoms in Palliative care, especially at the end of life. Agitation and delirium can usually be managed effectively when small doses of medication are titrated against symptoms.

PE 1.F453

Prevalence and severity of fatigue in diferent groups of advanced cancer patients

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Introduction: Fatigue is a common in advanced cancer patients, and probably one that worsens most the quality of life.
Aim: Studying the prevalence and severity of fatigue in diferent groups of advanced cancer patients.
Methods: The study analyzed two diferent groups of advanced cancer patients from the same hospital. A group from the oncology department, in diferent stages of the disease (43,8% were palliative care patients) (A), and a group of cancer patients referred to palliative care consultant team in the first evaluation (B). Inpatients and outpatients were included. The results were compared with a third group of advanced cancer patients (35% in palliative care) from a different hospital (C) (Salminem, 2008). All patients were evaluated with the ESAS questionnaire. Severity was mesured with verbal numerical scale (0-10) of ESAS. The means of each symptom score were calculated and fatigue score was re-grouped into three levels (0: no fatigue, 1-3: mild, and 4-10 moderate to severe fatigue).
Results: The patients included were 171 (A), 404 (B) and 203 (C). Patients from each group were comparable except in the primary tumors. Gastrointestinal tumors predominated in groups A and B, and breast and prostate tumors were the most frecuent in group C. The results showed fatigue in 81% (A), 90% (B), and 86% (C); moderate to severe fatigue in 52% (A), 79% (B), and 51% (C). Prevalence of moderate to severe fatigue were higher in inpatients 86% (A) and 82% (B) than in outpatients 35% (A) and 76% (B). In group B no significant differences were found in the fatigue scores of compared tumors. Female patients presented significant higher scores of fatigue than male patients. Fatigue was the symptom that scored the highest mean (A:3,9 [SD2,9], B:5,92 [SD2,9], C:3,8 [SD2,8]).
Conclusions: It could be stated that 80% of patients receiving palliative care showed moderate to severe fatigue. Our results suggest that fatigue is higher among hospitalized and female patients.

PE 1.F454

An observational study of the association between physical and psychological symptoms in patients with advanced cancer

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Aim: To look for an association between anxiety and/or depression and "distressing" physical symptoms in a cohort of palliative care patients at a UK

oncology centre.
Methods: This was an observational study conducted at the Royal Marsden Hospital (Surrey). Patients were asked to complete the Hospital Anxiety and Depression Scale (HADS) and the Memorial Symptom Assessment Scale Short Form (MSAS-SF: a validated tool that assesses the presence/distress caused by physical and psychological symptoms).
Results: 120 patients completed the study. The mean age was 61 years, there were 65 (54%) women, and the range of cancer diagnoses was representative of referrals to the palliative care service.
15% of patients met the criteria for anxiety using the HADS. There was a correlation between the anxiety score with the HADS and the score on the psychological subscale of the MSAS-SF (P > 0.001), and the overall MSAS-SF score (P = 0.037). However, there was not a correlation between the anxiety score with the HADS and the physical subscale of the MSAS-SF (P = 0.18). 25% of patients met the criteria for depression using the HADS. There was a correlation between the depression score with the HADS and the score on the psychological subscale of the MSAS-SF (P = 0.014), the physical subscale of the MSAS-SF (P = 0.046), and the overall MSAS-SF score (P = 0.015).
Conclusions: This study demonstrates an association between distressing physical symptoms and the presence of depression (but not anxiety) in patients with advanced cancer. These results have implications for clinical practice: patients with depression should be assessed for "distressing" physical symptoms, which should be actively managed in addition to psychological and pharmacological interventions for the depression.

PE 1.F455

The utilization of laxatives in a palliative care unit associated with pain control

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Constipation is one of the most frequently observed side effects regarding the drug utilization for pain in cancer patients, reflecting negatively on their quality of life. Studies show that, after the opioids analgesics, the laxative represent the second most prescribed class of drugs in palliative care. It occurs in approximately 40% of patients referred for Palliative Care Services and 90% of those treated with opioids.
The purpose of this study is to assess the profile of the use of laxatives in hospitalized patients, followed up in outpatient and home visits by a multidisciplinary team in a palliative care unit in Brazil. For both, was made a retrospective analysis of medical prescriptions in a given period. The laxatives standardized at the institution are pure mineral oil, glycerin suppository 95%, and 12% glycerin clister and bisacodyl 5mg. These were evaluated on their frequency of use, sex and association with opioid use. The results show that 40% of estimated prescription contained laxatives, being prescribed in the proportion of 49% to 51% for men and women. The association between laxatives and opiates was observed in 85% of the prescriptions analyzed, and the results were equivalent to those available in literature. The mineral oil was the most prescribed laxative in three segments analyzed (hospital, clinic and home visits) followed by its association with the glycerin suppository. With this study, we intend to develop a protocol for treatment of constipation and monitor the use of laxatives in the unit, especially when associated with the use of opioids for control of cancer pain.

PE 1.F456

Pressure ulcer in palliative care: Understanding the issue

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Cancer is a disease that induces systemic changes, such as hypermetabolism, with energy expenditure at rest, depletion of nutrients and protein, which leads the patient to weight loss and cachexia, raising the risk of forming a pressure ulcer. The nurses objectives in palliative care unit´s should be to promote comfort and dignity for patients, through actions in the control and treatment of symptoms, this includes the prevention and appropriate treatment of a pressure ulcer that are directly related to the patients quality of life. This study aimed to analyze the state of the art concerning the treatment of pressure ulcers in cancer patients and review the scientific literature regarding the treatment of pressure ulcers. There has been no systematic review of literature in meta databases of MEDLINE, LILACS, BDENF, PUBMED, in period of 1997-2007, categorizing the articles as the strength of evidence for trials of the Oxford Center for Evidence - based Medicine. The sample of the study consisted of 11 articles. The formation of pressure ulcers by cancer in some patients, especially those who are in the terminal stage of illness, should not be seen as a failure of care, but as a result of advancing disease causing physical deterioration, thus, the formation of ulcers pressure may be inevitable. The healing of ulcers pressure on patients with cancer shows no significant difference with respect to patients without cancer, however individuals with neoplastic disease have more risk factors and the formation of these lesions tend. This study does not support a decision to guide the work in treatment of pressure ulcers in cancer patients, but the knowledge gained in this study is valid, it reveals the paucity of works on the proposed topic. Therefore, the development of research that can fill the existing gap in scientific knowledge concerning the treatment of pressure ulcers in cancer patients is needed.

PE 1.F457

Administration of subcutaneous potassium infusion in advanced cancer patients

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Aim: Hypokalemia is commonly encountered across all medical settings, including Palliative Care. Depending on the goals of care and the clinical situation, hypokalemia is treated to prevent serious symptomatology. To date there have been no studies to investigate the use of potassium choride given subcutaneously as treatment of hypokalemia in the advanced cancer population.
There are a few anecdotal literature reports of the use of potassium chloride via hypodermoclysis prior to 1982. The majority of subsequent data mentions the subcutaneous use of potassium only as secondary outcome in a mixed population. Only one study by Schen and Arieli looked at the use of potassium chloride via subcutaneous infusion, but this was in elderly, non-cancer patients. Although our Regional Palliative Care Program has accumulated several years of experience with the administration of potassium via clysis and considers it standard practice, it has not been extensively and independently investigated. We are reporting on the usability and effectiveness of this route of potassium administration in advanced cancer patients.
Methods: We conducted a chart review of all patients admitted to a tertiary palliative care unit and a hospice unit over a one-year period between January and December, 2006. We collected data pertaining to the provision of subcutaneous administration of potassium.
Results: We will describe the use of subcutaneous administration of potassium in terms of frequency of administration, dose, tolerability and effect on serum potassium values.
Conclusion: This retrospective study provides previously unrecorded information to support the subcutaneous administration of potassium via clysis, a helpful method for the correction of hypokalemia in the advanced cancer population.

PE 1.F458

Cancer related fatigue and opioids

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Introduction: Cancer related fatigue (CRF) is one of the most bothersome symptoms in terminal cancer patients under hospice care. Opioids are widely used in the management of cancer pain. CRF is a multifactorial problem and its causes have not been clearly established till now. It is argued that drugs acting in the central nervous system, like opioids, can be responsible for the amplification of CRF by the inhibition of the reticular system. However, there is almost no research on it. Drowsiness and sluggishness are frequently observed during opioids administration. Can they be accountable for CRF to some extent?
Aim: This study focuses on the probable relationship between opioids and CRF in terminal hospice cancer patients.
Methods: 150 terminal cancer patients (68 male and 86 female) being under hospice care were examined with VAS- fatigue. The information on the pharmacological treatment was collected. The whole group was divided into 3 subgroups (without opioid, with tramadol and with strong opioid - morphine, fentanyl or morphine plus fentanyl) Afterwards, the correlation between the level of fatigue and taken opioid was performed by means of using the multivariate analysis ANOVA.
Results: Mean intensity of CRF in none, tramadol and strong opioid group were 5,4; 6,2 and 5,9 respectively. The differences in the level of fatigue between the groups were non- significant. It is vital to mention that the comparison of CRF levels in groups without opioid and with tramadol has the border significance at p 0,07.
Conclusion: The influence of opioids on the level of CRF does not seem to be as important a factor as it was previously assumed.

PE 1.F459

Microbiological profile of a palliative care unit: The multidrug resistance concern

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Background: The role of the Hospital Infection Control Committee (HICC) in palliative care units is under structuring process and there are few studies in the literature about its role. With regard to the multidrug resistance germs there are few data in the literature and there is not consensus on whether or not to intervene in the control of these germs, particularly the MRSA.
Objectives: To present the results obtained by HICC in a palliative care unit about the incidence of multidrug resistance germs.
Methodology: A prospective study, quantitative data collected from January to September 2008. The forms were filled with the following data: characteristics of infectious episodes, and microbiological culture results and sensitivity. For the calculation of the multidrug resistance rate of was taken into consideration the organism isolated in cultures performed in the unit.
Results: The profile of resistance to antibiotics has shown, in an average year, multidrug resistance microorganisms from 13,8% in a total of 290 positive cultures performed, and the incidence to: MRSA 3,8%, ESBL 7,2%, and other Gram negative bacteria 2,4%. There were no reports of MRSA infections, only colonizations, and the main site was the nasal mucosa. As producers of ESBL, the main site observed was urine, where both colonizations as infectious process themselves, with clinical manifestations. The most positive cultures were obtained from wards inpatients, but considerable samples were obtained from transferred patients, specially for MRSA that represented 63,6%.
Conclusion: Even in a Palliative Care unit, the presence of multidrug resistance germs was high. The incidence rates of MRSA were similar to that found in the literature, however the incidence of Gram negative bacteria and the presence of frequent clinical manifestations (infection) and the incidence of MRSA from transferred patients represents a issue in palliative care that needs a special concern.

PE 1.F460

Descriptive study of decision making by palliative care, aged care, aged care psychiatry, and oncology nurses caring for confused patients in the inpatient care setting

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Introduction: Delirium management impacts significantly on palliative care nursing practice. The aim of this study was to understand and compare assessment, management, and challenges faced by nurses from 4 clinical areas when caring for a confused patient.
Methods: Inpatient nurses in palliative care, aged care, aged care psychiatry and oncology participated in semi-structured interviews exploring views about symptoms, causes of distress, aspects requiring management, reversibility, and intervention choices. The interviews were taped and transcribed. Purposive sampling was used and interviews conducted until thematic saturation reached. A thematic content analysis was performed (three researchers coding transcripts independently with confirmation by participants).
Results: 40 nurses participated (n=10 for clinical area). Delirium was defined as cognitive or behavioural disturbance, often with likely precipitants included. Varied views existed about delirium reversibility, and assessment needed. The significant distress experienced by patients, families and health professionals was described. Familiarity and views about pharmacological strategies differed. A common view was intervention was not needed if distress and safety were not concerns. Many nurses felt strongly one on one nursing was an effective strategy for care (ability to use activity, talking to patient, and attention to the environment) however limited by budget or resource restraints. A major challenge was trying to balance care for the confused patient without jeopardising care for other patients. Most nurses felt confident in managing confusion informed by clinical experience.
Discussion: The limited symptom domains described supports literature regarding delirium under-detection. This study supports that delirium is a distressing experience. Hands on approach to nursing care was highly valued yet difficult to achieve, with quite varied medication use mainly for distress or safety.

PE 1.F461

Pilot study to examine the use of radio-opaque markers to measure colonic tranist times in palliative care patients

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Aims: In the palliative care population, constipation is a significant problem, negatively impacting symptom control and quality of life. In addition to the individual´s experiences, constipation has health care cost implications with constipated patients increasing nursing time and likelihood of hospitalizations. There numerous potential and proven contributing factors, that have resulted in prevalence's of up to 50% of people at the time of referral to palliative care services, with this figure increasing to 90% of people admitted to inpatient palliative care units described as constipated.
Within the functionally constipated population, slow transit of matter through the colon is identified as a major pathology. Likewise, numerous reasons for palliative care patients to have slow transit exist including medications, increasing debility, poor appetite, metabolic abnormalities and paraneoplastic phenomena, but only one previous study has examined this. This is contrast to other populations where investigations of this problem are commonplace.
This study aims to investigate whether the use of oral radio-opaque markers and plain abdominal x-rays, a commonly used approach to diagnosis slow colonic transit constipation in the general population is tolerable for palliative care patients. Furthermore, the study aims to explore whether there is a relationship between slow tranist and people´s reports of constipation.
Methods: Eligible participants will receive oral markers on three consecutive days and two subsequent abdominal x-rays. Using a validated formula, total and segmental colonic times will be calculated. Tranist times will be compared with "normal" populations and considered with the symptoms expressed by particpants. The tolerability and acceptability of this approach will be considered.
Results: Preliminary data from the first participants will be presented.

PE 1.F462

Involuntary movements in terminally ill patients - Diagnosis and treatment

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Aim: Terminally ill patients sometimes present with involuntary movements. The most common movements are myoclonic jerks associated with opiod overdosing. However, there is a variety of involuntary movements which is often underdiagnosed. Diagnosis is of some importance since the underlying metabolic or physiologic changes might be treatable.
Materials and methods: We report on documented (some also video-documented) involuntary movements of patients at our palliatve care unit from October 2006 until March 2009.
Results: The most often documented involuntary movements are myoclonic jerks associated with opoid overdosing. However, these jerks might also be seen in cervical spinal cord lesions and as a sign of progressive muscle wasting when patients move their extremities. Furthermore, myoclonic movements are common in patients with renal insufficiency as twitched convulsive syndrom. Only one patient showed the painful-leg-moving-toe-syndrom as a result of an illiacal abscess. Myoclonia can be very subtile as only the ankle of the mouth is moving. In the face we sometimes see patients with chin and in the mouth palatal myoclonia which occurs usually in the very last days of life. Oculomotor abnormalities like epileptic nystagmus is common in non-convulsive epileptic seizures.
In case treatment might be necessary, useful options include midazolam, valproic acid and levetiracetam.
Conclusion:
1. Involuntary movements might be more common in terminally ill patients than suspected.
2. An underlying metabolic or physiologic change must be evaluated since it might be treatable.

PE 1.F463

Emotional reactions of symptoms and functions among patients with advanced cancer in the end of life

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Background: Experiences of symptoms among patients with advanced cancer are often distressing and affect quality of life negatively.
Aim: The present study was performed to investigate the association between functional status and symptoms with emotional reactions and quality of life among patients with advanced cancer in the palliative care trajectory.
Method: This cross-sectional study used the EORTC QLQ C-30 to measure patients self-reported functional status, symptoms and quality of life.
Results: 278 patients with a mean age of 67 years completed the questionnaire. 62% were female and median time of survival was 43 days. Preliminary results indicate a difference in the association between the investigated functions and symptoms and the association with emotional reactions and with quality of life. Social functioning and fatigue seems to be most associated with patients perceived quality of life (correlation coefficients of 0.53 and 0.31 for patients having <30 days to live). Cognitive functioning and sleep disturbance seems to be most associated with emotional reactions in terms of being tense, feeling irritable, depressed and worried (correlation coefficients 0.48 and 0.48 for patients having <30 days to live).
Conclusion: As symptoms among patients with advanced cancer are highly prevalent, the knowledge about reactions, beside the intensity, of symptoms is important. Associations between symptoms and functions reported in the EORTC QLQ C-30 and emotional reactions and quality of life in relation to time of survival will be further explored and discussed.

PE 1.F464

Nursing intervention to control malodorous in malignant cutaneous wound

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The wounds are formed by the tumor cells from tumor infiltration into the structures of skin, due to uncontrolled cell proliferation that occurs break the integrity of the skin leading to the formation of the wound. These are classified as: ulcerative malignant wounds, malignant fungus wounds, malignant fungus ulcerated wounds. As for the staging in stage 1, 1N, 2, 3 and 4. The main complications that may be present in these wounds are: malodorous, itching, bleeding, pain, exudate and necrosis. The malodorous is said as the most distressing symptom for patients. The presence of malodorous causes the patient remember to use disease and may lead him to depression and social isolation, and other psychosocial problems, causing deterioration of the quality of life. The purpose of this study is to analyze through the clinical indicators of quality in the period from March to August 2008, the intervention of nursing in controlling the malodorous of malignant cutaneous wound, according to institutional protocol in the sector of an outpatient hospital specializing in palliative care - Brazil. Data are collected in separate instrument and evaluated quantitatively, these are presented in tables and graphs. In this period there were 119 Malignant cutaneous wound with malodorous. Given the prevalent locations: head and neck, breast, bone and connective tissue, gynecological and anal. Of these 55 were not reviewed, due to the death of the patient, change of type of assistance or do not return to nursing consultation; 38 had effective control of the malodorous; 09 worsen the malodorous and 06 remained with grade 1, 09 with malodorous degree 2 and 02 with the malodorous grade 3. We concluded that the interventions of nursing to control the malodorous in wounds tumor were effective, despite the difficulties encountered in this control. Contributing to a better quality of life of patients in palliative care in this unit.

PE 1.F465

Symptom prevalence in cancer patients referred to the first specialist palliative care clinic in Egypt

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Aim: Research is essential to establish and develop palliative care in different cultures and settings, whatever the resources. Like other developing countries, cancer patients in Egypt frequently present in an advanced stage. Although the only realistic treatment approach for these patients is palliative care, it is still in the very early stage of development in Egypt. In this brief report, we present the preliminary results of a study aiming at estimating the physical symptoms burden in cancer patients referred to the first hospital-based specialist palliative care clinic in Egypt.
Methods: A retrospective review of the medical records of cancer patients referred to a palliative care clinic during the first two months since its opening. The physical symptoms reported by cancer patients during their first visit to the palliative care clinic are described.
Results: During the study period, the palliative care clinic received 29 new cancer referrals. Their median age was 52 years (range, 17-73) and 45% were males. The most common primary cancer was gastrointestinal (24%) and 72% of patients had distant metastases. Twenty physical symptoms were identified and the median number of symptoms per patients was three (range 1-7) and about one third had at least five symptoms. Pain was the most common symptom and occurred in 90% of patients followed by weakness in 45%, constipation in 38% and vomiting in 24%.
Conclusion: Although the number of patients included was small, the results give an idea about the high prevalence of physical suffering in Egyptian advanced cancer patients. Further prospective studies using validated Arabic assessment tools are warranted to

confirm our results and to explore other aspects of suffering. There is an urgent need to develop and spread palliative care models suitable for the Egyptian culture in order to improve the quality of life of advanced cancer patients and their families.

PE 1.F466

Radiation therapy in malignant spinal cord compression. What is the current knowledge in this field of palliative medicine? A literature review

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Background: Malignant spinal cord compression (MSCC) in patients with short life expectancy is most frequently treated with radiotherapy and/or corticosteroids. Hypofractionation is proven efficient in metastatic bone pain and lung cancer, but the level of evidence for hypofractionation in MSCC is limited.
Materials and methods: Searches were performed in PubMed, EMBASE and the Cochrane Library for all relevant articles. They were systematically assessed and categorized as follow: Systematic reviews, randomized controlled trials (RCT), prospective non-randomized trials and retrospective studies.
Results: One RCT was identified, comparing hypofractionation (8 Gy x 2) with a more fractionated regimen. In this study no differences in ambulation, survival or toxicity were detected. The five prospective non-randomized studies identified revealed no differences in post treatment motor function. Of 17 retrospective studies the largest included 1304 patients, treated with five different regimens ranging from 8 Gyx1 to 2Gyx20, and found similar post treatment ambulatory status. A Cochrane review based upon the only published RCT concluded that short courses of radiotherapy appear to be justified in poor prognostic patients.
Discussion: Hypofractionation has proven efficacy in the treatment of metastatic bone pain, and the current knowledge on the pathofysiology of MSCC can indicate that hypofractionation might be efficient in this condition as well. Short course radiotherapy regimens are considered positive both for the patients and the society.
Conclusion: The level of evidence as to which radiation schedules are the most effective is low. Short courses of radiotherapy appear to be justified in poor prognostic patients, but there is a need for large randomized trials in non-selected patient cohorts before any final recommendations can be given.

PE 1.F467

Use of Midazolam with elderly patients at the end of life: A study of 20 cases in a palliative care unit (10 patients>100mg/day)

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Introduction: Pain and intense fear are characteristic for advanced cancer even with elderly patients. This retrospective study analyses such cases with intravenous (IV) or subcutaneous (SC) dose of more than 50 mg/day of Midazolam in the terminal phase.
Method: Ex-post analysis of 20 elderly patients received consecutively, with Midazolam administered for intense fear or upon request for linked sleep.
Results: Average age 72 years [63-92], of which 7 > 80 years. Pain is being self evaluated or hetero-evaluated with the ECS behaviouristic scale. Fear and request for linked sleep is being self or hetero-evaluated. Average length of stay in the service: 41 days, of which 18 with Midazolam.
Midazolam dosage always is progressive and varies between 5mg/day on the beginning and 240 mg/day in final phases [5-240 mg].
For 10 patients (4 men, 6 women) the dosage is higher than 100mg/day IV or SC: for this subgroup were discovered: 1 psychic decompensation, 5 increased dosages until final phase, 4 sedation.
Analysis: Important doses are sometimes required to induce sleep. Some patients (3/9 who received >100 mg) fight against sleep while having requested it. Sedation continues to be a complex question, psychological and ethical.
7 patients were pronounced respiratory insufficient (SaO2<85), and fear was better after Midazolam without clinical distress. It request a rigorous surveillance, the more IV way is very efficient and fast, but shows risk of anaesthesia (no patient needed Anexate*), and Midazolam may increase the respiratory depression of opio?ds (but no patients needed Naloxone, even with doses>100mg/day).
Conclusion: Midazolam is efficient in cases of elderly patients with fear. Gradual use necessitates ethical references and strict compliance with the recommendations of SFAP, assistance of a decision making tool (DDE), procedures in place to evaluate efficient and non-excessive dosages, permanent personal contact with family members to explain medical strategies.

PE 1.F468

Facial burns in connection with oxygen insufflation in home-based palliative care

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We report about a 48 year old patient receiving specialized out-patient palliative care with diagnosis of SCBC. He was suffering from pain and repetitive dyspnoea. It had been possible to secure reasonable symtom relief by treating him with morphine and lorazepam over a long period.
At oxygen saturation of 93-98% an oncologist prescribed an oxygen concentrator. Despite detailed information about the risks, given by a palliative doctor, the patient smoked while inhaling O2, which caused a sudden flame to burn the right side of his face causing second degree burns.
Making use of the mobile phone service MMS we were given advice by the centre for serious burn injuries and were able to continue treatment at home. Despite secondary infection the burns healed within four weeks without leaving scars using Fusidin acid ointment.
Discussion: While the use of oxygen in emergency cases is valued highly, its use for palliative care is increasingly being questioned. It is undisputed that a patient can experience physiologically justified relief of dyspnoea if oxygen saturation in his blood is reduced (SO2<92 %).
In most cases dyspnoea is caused by hypercapnia. Giving oxygen can only - if at all - help psychologically. The disadvantages are not to be ignored; these can be dependency on medical technology (tube, oxygen concentrator), drying up of the mucous membrane, irritation caused by noise, and disturbed communication due to facial masks. Recently it was shown that dyspnoea can be treated much more successfully by the application of benzodiazepines or opioids.
Conclusion: The application of oxygen for the treatment of dyspnoea rarely makes sense and, as in the cited case of nicotine abuse, it can cause severe facial burns. In the case of care at home advice from a burns specialist can be obtained by means of new technical facilities (mobile phone - MMS).
It should be compulsory to put a large warning sign on oxygen concentrators "No Smoking".

PE 1.F469

Are questions about diagnostics and treatment of psychiatric disorders in patients with palliative care needs a reason to consult the palliative care team in a university hospital in the Netherlands?

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Within the UMCG, a multidisciplinary palliative care team was set up in 2006. Patients are seen on a consultation base.
Previous studies in palliative care patients showed that anxiety and depressive disorders are prevalent but under diagnosed.
To study whether doctors who referred patients to our team were aware of psychiatric problems of their patients.
A retrospective study of patients referred to the palliative care team from October 2006 to October 2008.
In this period 170 new patients have been referred. In 34 of the patients a psychological or psychiatric problem was reason for referral. Of these 34 patients 21 had these problems. The remaining 13 patients were adapting from recently given bad news. The 21 patients were assessed by a psychiatrist or social worker. Only 3 of them were diagnosed with a anxiety or depressive disorder.
Of the 136 patients who were referred for other indications, 26 patients were diagnosed with psychological/psychiatric problems also. Half of them were diagnosed before referral. Three of them had an anxiety or depressive disorder. The other 13 patients had psychological/psychiatric problems diagnosed by our team.
Of the 47 patients seen by our team with these problems, 23 had problems with acceptation and coping. A problem in the doctor-patient relationship was found in 12 patients.
Diagnostics of anxiety and depressive disorders are rarely a reason for referral to our palliative care team. However, patients with coping problems and problems in the doctor-patient relationship are frequently seen. Maybe doctors do not recognise anxiety and depressive disorders, or if they consider it, patients are referred to another discipline. Although we are aware of anxiety and depressive disorders, our team might miss this diagnosis.

PE 1.F470

The influence of morphine and tramadol on cancer patients' cognitive functions

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Background: Tramadol and morphine are used in pain treatment . In spite of common use of these drugs, we still don't exactly know how they influence on human cognition.
Aims: The aim of our study was to assess:
- The correlation between tramadol or morphine, and cognitive functions of cancer patients
- The influence of the dosage of drugs and their blood concentration on cognitive functions
- The correlation between general patient state (ECOG) and cognitive functions.
Material and methods: People, who were taken under the consideration, had to be in advanced state of cancer disease, in good mental condition (Mini- Mental state), loss of treatment with papaverine and codeine during four weeks before the investigation, psychical status (ECOG scale less than four).
Paper (BFI, HADS-M,VAS) and computer tests(Cognitive Drug Research) has been used. We've examined patients twice: before and after taking a drug. Results has been analysed by statistic program - STATISTICA Pl.
Results: 93 patients of both sex have been examined. Patients treating with tramadol improve verbal and spatial memory. They make worsen in tests assessing attention speed and quality. Comparing patients treated with morphine worsen in short term memory, long term memory and attention tests.
Conclusions: Morphine and tramadol influence on some cognitive function. Morphine influences more than tramadol on cognitive functions in cancer patients. General state (ECOG scale)correlates with cognitive impairment.

PE 1.F471

Effectiveness and tolerability of senna tea combined with lactulose syrup in patients with intestinal constipation

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Aims: Constipation is one of the most common problems in hospital inpatients receiving palliative care, and can cause extreme suffering and discomfort. The combination of a stimulant and a softener laxative has been recommended for management of constipation in palliative care. The objective of this study was to evaluate the effects and tolerability of senna tea combined with lactulose syrup administered orally and via gastrostomy and enteral tubes in terminally ill cancer patients with intestinal constipation.
Methods: 15 hospital inpatients were treated with senna tea (1g /200mL) and lactulose syrup (20g /30mL) once daily. The dose was adjusted when required and a diary was kept to monitor dose, side-effects, stool frequency and consistency, and other symptoms. Rectal treatments (suppositories or enemas) were implemented when needed.
Results: Laxatives administered via gastrostomy and enteral tubes showed no dissimilar effects compared to those orally given. The first bowel motion occurred at a median of two days after the implementation of laxative treatment. 11(73%) patients showed

Improvement in stool consistency and frequency ($P < 0.01$) and the number of stools per week was also significantly higher ($P < 0.01$). Individuals presented bowel movements every 2 days with normal stools (types 3 or 4 accordingly to Bristol Stool Scale). In 1 (7%) patient the occurrence of flatulence required lactulose to be discontinued and paraffin oil was initiated instead. No other side effects were detected and tolerability was good for all subjects. Patients described the senna infusion combined with lactulose as "sweet", "enjoyable" and "tasty".
Conclusion: The combination of senna tea with lactulose syrup seems to be helpful in the management of constipation. Furthermore, its pleasant taste may be a suitable way to increase its acceptability and encourage fluid ingestion in palliative care patients with intestinal constipation.

PE 1.F472

A methodological exploration of symptom clusters in patients with inoperable lung cancer

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Aims: The objectives of the study were to inductively explore the existence of symptom clusters among a homogenous group of patients with inoperable lung cancer close to diagnosis, and to explore if the resulting symptom clusters are consistent when examined with different instruments and analytical methods.
Study design and methods: A cross-sectional study was conducted of 400 patients newly diagnosed with lung. Forty-eight percent were women. Data was analyzed from two questionnaires, European Organization for Research and Treatment of Cancer's QLQ-C30 and LC13; and the Symptom Distress Scale. Items in the instruments were adapted to increase their correspondence. Symptom clusters was analyzed with Pearson's correlations, cluster analysis, factor analysis and Cronbach's alphas.
Results: Three clusters were found to be notably consistent across instruments and analyses: first, a cluster consisting of pain, nausea, bowel problems, appetite loss and fatigue; second, a mood cluster consisting of mood, outlook, concentration and insomnia; and third, a respiratory cluster consisting of breathing and cough, with fatigue and appetite loss closely related to more than one cluster in several analysis.
Conclusions: We found consistent symptom clusters for a large cohort of lung cancer patients at a comparable point in their cancer trajectory, across different measurement tools and statistical methods. This is important, as the relevance of symptom cluster research is questionable if there is a lack of consistency across data collection and analysis approaches. Fatigue and appetite loss were related to more than one cluster, indicating the need for further study of these symptoms, with consideration of clinical and not only statistical features.
Acknowledgement: The Swedish National Research Council, The Swedish Cancer Society, The Swedish Heart-Lung Foundation, The Swedish Foundation for Health Care Sciences and Allergy Research, and the Center for Health Care Sciences at the Karolinska Institutet, Coop Sweden.

Poster sessions (Saturday)

PE 2.S1

Evoked brain potentials connected with tactile sensations, skin and joint pain as the chance of palliative care objective assessment

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Aims: Objective characteristics of pain is an important problem for investigation. We examined 17 volunteers in poststimulus skin and joint pain induced by focused ultrasound. Pain threshold were measured psychophysically, brain potentials were evaluated electroencephalographycally and they both were compared.
Methods: 1 ms and 5 ms impulses of 2.5 MHz focused ultrasound were used. Ultrasound stimuli were directed in the skin of the finger tip and into the finger joint being repeated from three to dozens times.
Results: Evoked by ultrasound electrical brain potentials connected to skin and joint poststimulus pain (PP) differed from evoked tactile k-complexes, in the increase of the third amplitude oscillation and in the time of oscillation reversal to the isoelectric level. Brain potentials did not depend on the kind of pain (skin or joint PP) as well as on the place of PP, for example on the finger or on the cheek skin and allowed to evaluate pain intensity and duration.
Conclusions: Objective measure of PP intensity and duration was shown in comparison with tactile sensation and pain. There was no difference of PP potentials for poststimulus skin and joint pain.

PE 2.S3

The validation of the French Brief Edinburgh Depression Scale (BEDS)

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Aims: Depression is an important symptom for many palliative care patients but is rarely identified. The Brief Edinburgh Depression Scale is widely used within the UK and also in other countries but its use is limited due to its lack of translation. In this study we report the translation and validation of the BEDS in the French Language.
Method: A group of experts were convened to translate the BEDS using back-to-back translation and the standard procedures of the EORTC. The French BEDS was then validated on day 1 and day 7 within an in patient palliative care population against a semi structured psychiatric interview.
Results: Forty-eight patients participated in the validation study. The prevalence of depression according to psychiatric interview was found to be 56.3%.
In our study with a cut off of 6, we found a sensitivity of 90% (95% CI 55,2 - 100) and a specificity of 63% (95% CI 41,5 - 84,8) and a PPV (positive predictive value) of 0.788 and a NPV (negative predictive value) of 0,800. For a cut off of 6, prevalence of depression was 68.8%. (vs 56,3% by interview) and the optimum cut off of the French BEDS was 7, which yielded a sensitivity of 82.4% and specificity of 68.4%. The reliability of the scales (Cronbach´s Alpha) reached acceptable levels (0.715 for the BEDS D1 and 0,843 for the BEDS D7).
Conclusion: We believe the French BEDS is a valid and sensitive tool for the screening of depression and can be used within the palliative care population. We suggest further work may allow the French BEDS to be used within the wider oncology population.

PE 2.S4

Validation of the Danish Barriers Questionnaire II

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Aims: The Barriers Questionnaire-II (DBQ-II) is a revised tool assessing cancer patients' concerns about pain management. The objective of this study was to examine construct validity and internal consistency of the Danish version of the BQ-II (DBQ-II).
Methods: Cancer patients for the study were recruited from specialised pain management facilities. Thirty-three patients responded to the DBQ-II, the Hospital Anxiety and Depression Scale (HADS), the Brief Pain Inventory (BPI) Pain Severity scale, and demographic and disease-related questions. Statistical analysis was performed with SPSS 16.00 and included: factor analysis of the DBQ-II, correlation analysis between the DBQ-II and the HADS and the BPI, assessment of associations between the DBQ-II and demographic characteristics, and assessment of Chronbach alpha of the DBQ-II.
Results: A factor analysis of the DBQ-II resulted in five factors. Factor one, Communication, consisted of five items addressing the concerns that reports of pain distract the physician from treating the cancer and that "good" patients do not complain. Factor two, Fatalism, consisted of three items addressing fatalistic beliefs regarding cancer pain management. Factor three, Immune System, consisted of three items addressing the belief that pain medications harm the immune system. Factor four, Monitor, consisted of three items, addressing the fear that pain medicine masks changes in one's body. Factor five, Addiction, consisted of two items addressing the fear of becoming addicted to pain medication. Items related to medication side effects and tolerance were analysed separately. The DBQ-II total score was negatively correlated to pain relief and positively to anxiety. The internal consistency alpha of the DBQ-II was 0.87.
Conclusion: The DBQ-II seems to be a valid and reliable measure of barriers to pain management among Danish cancer patients.

PE 2.S5

The Danish version of the questionnaire on pain communication: Validation in cancer patients

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Aim of research: The Modified Version of the Patients' Perceived Involvement in Care Scale (M-PICS) is a tool designed to assess chronic pain patients' perceptions of the quality of pain communication with his/her health care provider. The objective of this study was to examine the psychometric properties of the shortened Danish version of the M-PICS (SDM-PICS) among cancer pain patients.
Methods: Cancer patients for the study were recruited from specialised pain management facilities. Thirty-three patients responded to the SDM-PICS, the Danish Barriers Questionnaire II (DBQ-II), the Hospital Anxiety and Depression Scale (HADS), the Brief Pain Inventory Pain Severity Scale (BPI), and demographic and disease-related questions. Statistical analysis was performed with SPSS 16.00 and included: factor analysis of the SDM-PICS, correlation analysis between the SDMP-PICS and other patient reported outcomes, and assessment of the internal consistency reliability alpha of the SDM-PICS.
Results: Factor analysis of the SDM-PICS resulted in two factors. Factor one, Patient Information, consisted of four items assessing the extent to which the patient shared information with his/her health care provider. Factor two, Health Care Provider Information, consisted of four items measuring the degree to which the health care provider was perceived as the one who shares information. Two separate items addressed the perceived level of information exchange between the patient and the health care provider. The SDM-PICS total score was inversely related to the measures of pain management barriers, anxiety, and reported pain levels. The SDM-PICS total had an internal consistency of 0.88.
Conclusion: The SDM-PICS is a short, reliable and valid instrument measuring the patient perceived quality of the communication with his/her health care provider in the context of cancer pain.

PE 2.S6

The project of a "clinical nutritional commission" in a hospital center (Oncology Institute and General Hospital) in Southern Switzerland

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In the management of cancer and other chronic diseases, delivery and intake of an adequate nutrition (both quantitative and qualitative) may result in improved outcomes (quality of life, response to medical treatments,...), in a reduction of disease and treatment-related complications as well as in favourable effects on shorter hospital stays and medical costs.
We identified consistent nutritional concerns and insufficient attention to this issue in our institutions. In September 2007 we developed the idea of creating a "Nutritional Commission" at the Oncology Institute of Southern Switzerland and at the Regional Hospital of Bellinzona, in order to address this topic, clearly recognized as a priority from many colleagues. We started with a sensitizing campaign among the personal of the different departments of the two institutions. A nutritional screening at hospital admission (Nutritional Risk Assessment Form), a continuous daily follow up of the food intake and dietary consultations were delivered in three "pilot units" (Palliative Care, Radiation Oncology and Internal Medicine). Particular measures were considered according to the specific nutritional problems (further dietary consultancy and follow up, parenteral nutrition support, percutaneous endoscopic gastrostomy,...). Along the introduction of the project in the three pilot units, we encountered some problems that were mostly related to practical, administrative (competences), logistic and communication issues.
Our observation is that, extending a project of such a big dimension starting from three pilot units, it will be unavoidable to allocate dedicated human resources to follow the works in progress and to guarantee that both screening and interventional measures will be performed carefully and continuously. The poster will address the positive impact of the project but also discuss the major related problems as well as present preliminary data collected in the three pilot units.

PE 2.S7

The Distress Thermometer used in daily practice in advanced cancer patients admitted to a unit for palliative care

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Aim: The Distress Thermometer (DT) is a valid and easy to use screening instrument for assessing distress in cancer patients. Although the DT has been widely used in the outpatient clinic, the experience in inpatients is scarce. We designed a pilot study at the acute unit for palliative care (PCU) in our cancer hospital. We explored the following three questions:1. what is the feasibility of daily DT assessments in inpatients, 2. do DT scores change during admission and 3. what kind of problems induce distress (only asked when DT ≥5).
Methods: Oncology nurses applied the Dutch modified DT (a horizontal numeric scale ranging from 0 (no distress) to 10 (unbearable distress)) daily in patients without cognitive deficits and limitations in consciousness, admitted at the PCU.
Results: Between October 2007 and August 2008 120 patients were included. In 28 patients a DT score at admittance (DT-start) was missed. Reasons for missing data were: score was not given within 24 hours after admittance (n=18), too ill (n=4), too difficult to give a score (n=3), unknown (n=3). In 57 patients (out of 92) both a DT-start and DT-end score (before discharge or before death) were administered. Reasons for missing DT-end were: too ill (n=7), too difficult to give a score (n=5) and not further mentioned (n=23). In these 57 patients the median duration of hospital stay was 7 days (range 1-34). The median DT-start was 6 (range 0-

9; 74% ≥5), the median DT-end was 4 (range 0-10; 40% ≥5) (p=0.001). Reasons for DT-start ≥5 (n=42) were physical problems (n=25), emotional problems (n=3) or both (n=14). At DT-end (n=22) the reasons were physical problems (n=14), emotional problems (n=6) or both (n=2).
Conclusion: Administering the DT in daily practice seems feasible in patients admitted to a unit for palliative care, but special attention for continuity is necessary. During admission the DT scores decreased significantly. High DT scores (≥5) were mostly caused by physical problems.

PE 2.S9

Usefulness of the Palliative Performance Scale in prognostication for a Portuguese hospital-based palliative care team

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The Palliative Performance Scale (PPS) was recently validated as a valuable prognostic tool also within a hospital acute care setting. Despite PPS is already incorporated as standard practice in clinical assessment of Portuguese palliative care patients all PPS validation studies were carried outside Europe.
Aims: To explore the predictive ability of PPS in a Portuguese tertiary academic acute hospital setting.
Methods: The PPS score was assessed at initial consultation. Medical records of all patients enrolled in the hospital-based palliative care team program between February 1, 2007 and September 30, 2008 were reviewed. Survival patterns were examined for age, sex, diagnosis, PPS, initial consultation setting (in-patient / outpatient clinic) and death place.
Results: Among the 321 patients analyzed, 92% had cancer and 46% were seen by first time at outpatient clinics. Seventy per cent of the PPS scores were under 50%. Patients were followed for a median of 17 days (quartiles 6 and 48 days). By 90 days only 14% remained alive. One-month mortality rates were 95% for PPS scores 10-20, 56% for scores 30-50 and 20% for PPS >50. PPS score and death place had a significant effect on survival on multivariable Cox proportional hazards models (hazard ratio 0.96 and 2.77, respectively, p< 0.0001).
Conclusion: Initial PPS score was a strong predictor of survival in our setting. As on earlier studies three distinct PPS survival bands were found.

PE 2.S10

A comparison of palliative care outcome measures used to assess the quality of palliative care provided in residential aged care facilities: A systematic review

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This paper reports on the results of a Joanna Briggs systematic review conducted to assess the psychometric properties (reliability/validity) and feasibility of palliative outcome measures used to assess the quality of palliative care provided in residential aged care facilities. Data were obtained from searching Medline, Cinahl, EMBASE, Psych Info, Psych Articles, DARE, Cochrane Reviews, TRIP and hand searching key palliative care and aged care journals for articles published between 1/1/2000 and 1/9/2008. A total of 404 articles were identified of which 11 met the inclusion criteria. These 11 articles detailed nine different outcome measures. This paper compares the psychometric properties and feasibility of these measures including recommendations for research and practice.

PE 2.S11

Ultrasound diagnostic at home in palliative setting in abdomen and chest disease

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Aim: Palliative patients needs, less than other, to be scanned with diagnostic test, but several could be treated with more accuracy if more clinical elements are knew. Aim of the project is to ensure the best clinical impact reducing patient's and care givers stress.
Methods: We used a portable ultrasound system (brang at patient's home) to solve diagnostic questions and, when useful, to carry out invasive methodics without moving the patients from home. We used a 3,5 - 5 MHz convex array, to evaluate abdomen and chest disease. The US scan was assessed only if considered useful to emprove the care's outcome, according with palliative care philosophy.
Results: We evaluated, during the last year, 25 patients; we assessed totally 31 tests, 23 to solve diagnostic question about abdominal pain or distension, 5 for dyspnea and 2 to verify hitterus' origin. Has been diagnosed 16 abdominal effusion (5 drained with US guide), 5 abdominal distension due to bowel or oncologic disease, 2 urinary retention, 3 pleural effusion (1 drained with US guide), 1 pericardial effusion and 1 biliar dilatation. For 2 patients US scan wasn't diagnostic. However, nobody was candidate to second level procedures.
Conclusions: First level US imaging has to be considered an useful way to emprove the clinical accuracy in a home care unit, allowing to perform sure diagnosis reducing patient's discomfort, to carry out invasive methodics (drainage of abdominal or pleural effusion) in the safest way and to avoid useless acts.

PE 2.S14

Usefulness of screening tools for delirium in palliative care units

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Aim: Delirium is a prevalent, often stressing symptom in the palliative care unit (PCU). Studies in an elderly population have shown that awareness and preventive measures can influence the incidence of delirium. Screening instruments could help to diagnose delirium in an early phase.
The objective of this study was to test the usefulness of screening instruments for delirium in an overall PCU population.
Methods: DSM-IV criteria are used as golden standard for diagnosis of delirium. The Confusion Assessment Method (CAM) and the Delirium Observation Scale (DOS) were selected as screening instruments as these are validated in Dutch. Seventy two patients were recruted from 6 PCUs in Flanders.
Results: Mean age of patients was 69 years and 50% were male. Most patients had oncologic metastatic disease. 90% of these patients died in the PCU. The mean length of stay was 31 (IQR 3-209) days. The incidence of delirium in this group of patients was 27%, 34% and 75% as measured respectively by the DSM, CAM and DOS (original cut off of 3). The measure of agreement between the CAM respectively the DOS and DSM is low (?=0.248, p= 0.057; ?=0.156, p=0.043). The Crohnbach?s alpha is 0.837 for the CAM and 0.966 for the DOS. Factor analysis shows some symptoms to be more predictive than others.

	CAM	DOS (cut off 3)	DOS (cut off 6)
Sensitivity	37%	77%	40%
Specificity	93%	75%	92%
Negative Predictive value	93%	97%	93%
positive predictive value	39%	26%	36%

Conclusion: Screeningsinstruments for delirium (CAM, DOS) in a PCU have a low positive and a high negative predictive value. This makes them very useful to exclude delirium in a PCU patient population. To augment their use in diagnosing the presence of delirium in palliative patients, further research should focus on optimizing their positive predictive value.

PE 2.S15

Quality of life in palliative patients: Comparison of assessment tools and subjective well-being

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Background: The preservation and improvement of quality of life (QOL) for terminally ill patients is one of the main aims of palliative care. Many assessment tools for individual or health-related QOL are not practicable in palliative care settings because of impaired physical, cognitive and psychological status of patients. This study investigated whether extensive standardized instruments can be replaced by the single item question on well-being ("How do you feel today?") from the Minimal Documentation System (MIDOS).
Method: Since April 2008 patients receiving inpatient palliative care in the departments of palliative care, radiotherapy, oncology and in an inpatient hospice are asked to answer the Functional Assessment of Chronic Illness Treatment (FACIT-G), the QOL questionnaire of the European Organisation for Research and the Treatment of Cancer (EORTC-QLQ-C30), the Schedule for the Evaluation of the Individual Quality of Life (SEIQoL) and MIDOS. Correlations of sum scores describe the extent of congruency between the selected instruments.
Results:

	SeiQoL	FACIT-G	EORTC-QLQ-C30	MIDOS
SeiQoL		-.353*	-.171	.189
FACIT-G	-.353*		.331*	-.351*
EORTC-QLQ-C30	-.171	.331*		-.475**
MIDOS	.189	-.351*	-.475**	

*statistical significance < 0.05; **statistical significance < 0.01
Table 1: Spearman rank correlations of assessment tools on quality of life (SeiQoL, FACIT-G, EORTC-QLQ-C30) and MIDOS (N = 40).

Conclusions: Correlations between scores as well as with the question on well-being were low to moderate. However, the question on well-being may be useful to initiate communication with the patient on his quality of life.
Feasibility and limitations of the use of such questionnaires in palliative care settings have to be discussed.

PE 2.S16

Assessment of symptoms in hospitalized patients with advanced chronic diseases. Is there agreement between patients and doctors?

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The assessment of symptoms is a key component of clinical work and of quality of life studies in palliative care. In the literature there is a wide variation between symptoms assessments made by patients and by physicians.
Objective: To estimate the frequency and diagnostic accuracy in the evaluation of physical and psychological symptoms in chronic patients suffering advanced illnesses.
Method: This was a prospective study in adult palliative care patients with chronic advanced illnesses who were admitted to the internal medicine service at university hospitals, between January and September 2007. The patients completed the Edmonton Symptom Assessment Scale (ESAS) for the diagnosis of physical and psychological symptoms. Patients with delirium were excluded. The ESAS was simultaneously applied to the patients and their doctors to assess the level of diagnostic concordance between them. The measure of concordance was made with the Kappa index for paired samples.
Results: 148 patients met the inclusion criteria, 76 with advanced malignancies and 72 with other advanced chronic diseases. Among 124 patients without delirium, the frequency of symptoms was very high, ranging from 17.0 to 78.8%. Restlessness, sleep disorders and anorexia were the most common. The concordance between symptoms reported by patients and by doctors was very low, with Kappa index ranging between 0.019 and 0.135. The physicians had a tendency to underrate and to overrate symptoms. The symptoms more underrated were restlessness and anxiety and the more overrated were depression and appetite disorders.
Conclusions: In our sample of inpatients with oncologic and non-oncologic advanced illnesses, there is a very high frequency of psychological and physical symptoms that are inaccurately evaluated by the medical team. The use of physician assessments in palliative care patients should not be considered a reliable alternative to patient self-assessment.

PE 2.S17

The impact of pain behaviour on pain intensity in older persons with severe dementia: Reliability of the MOBID Pain Scale by video uptake

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Aim: Advancing age is associated with high prevalence of dementia, often combined with under-diagnosed and under-treated pain. The Mobilization-Observation-Behaviour-Intensity-Dementia (MOBID) Pain Scale is a nurse-administered assessment tool to unmask pain behaviour during standardized, guided movements and inferred pain intensity scores. It was the aim to examine intra- and inter-rater reliability of pain behaviour indicators, inferred pain intensity, and the overall MOBID pain score.
Methods: 26 nursing home patients with severe dementia and chronic pain, 11 primary caregivers and 3 external raters at the Red Cross Nursing Home, Bergen. During video uptake the patients were guided by their primary caregivers to perform standardized movements of different body parts. Pain behaviour indicators (pain noises, facial expression, defence) were registered for each movement with subsequent rating of pain intensity by external raters, who assessed and scored the videos concurrently and independently at day 1, 4 and 8.
Results: Facial expression was most commonly observed, followed by pain noises and defence. Repeated assessments increased the number of observed pain behaviours, but did not improve reliability. Inter-rater reliability was highest for noises, followed by defence, and facial expression (?=0.44-0.92, ?=0.10-0.76, and ?=0.05-0.76, respectively, at day 8). Mobilization of arms and legs were rated most painful. Intra- and inter-rater reliability of overall pain were very good (ICC 1,1 ranging 0.92-0.97 and 0.94-0.96, respectively, at day 8). Reliability of pain intensity scores tended to increase by repeated assessment.
Conclusion: Observation of pain behaviour is an important prerequisite for assessing pain intensity, but reliability of pain intensity scores is higher compared to reliability of pain behaviour indicators. Using video uptake, MOBID Pain Scale was shown to be sufficiently reliable to assess pain in older persons with severe dementia.

PE 2.S18

Comparison to a gold standard: Concurrent validity of the MOBID-2 Pain Scale

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Aim: Pain is common among nursing home (NH) patients with dementia, yet pain is often unrecognized and inadequately treated in this population. Pain assessment is a particular challenge in cognitively impaired patients due to poor self-report skills, and depends on the ability of health personnel to register and interpret pain behaviour. Although many pain assessment instruments have been developed for use in patients with dementia, these scales do not systematically assess pain from the musculoskeletal system, and other types of pain, such as pain originating in internal organs, the head and skin. It was the aim of this study to investigate inter-rater reliability and concurrent validity of the Mobilization-Observation-Behaviour-Intensity-Dementia (MOBID-2) Pain Scale using elderly NH patients without dementia as a gold standard compared to proxy rater.
Methods: NH patients (N=30) without or with mild dementia and with a history of pain, who was able to express pain, evaluated their own pain situation using the MOBID-2 Pain Scale. Concurrently and independently, the primary caregiver (proxy rater), a registered nurse or licensed practical nurse, used the MOBID-2.
Results: Inter-rater reliability of the different test items and overall pain intensity scores was excellent (ICC=0.89-0.97). Assessment of pain from internal organs, the head and skin (Part 2) showed a somewhat lower reliability than pain originating from the musculoskeletal system (Part 1) (ICC=0.89-0.97 and ICC=0.92-0.97, respectively). The correlation between proxies' and patients' pain intensity scores varied from poor to excellent.
Conclusion: Proxy assessment of pain using the MOBID-2 Pain Scale was found to correlate closely with patients´ self report, suggesting that the instrument is useful for making a reliable and valid assessment of pain and pain intensity.

PE 2.S19

A multi centre study of attitudinal barriers to cancer pain management

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Pain management remains a challenge in cancer care. Attitudinal barriers (e.g. fear of addiction, concerns about tolerance and side effects) have been found to negatively affect the quality of pain management and in turn quality of life (QOL) in cancer patients. While a body of work already exists on the importance of attitudinal barriers in cancer pain management, much needs to be known about such barriers and their cultural nature in an international context. The purpose of this study is to examine attitudinal barriers to cancer pain management in an international sample of patients with advanced cancer.
The study is based on a model developed by Ward and colleagues that proposes that attitudinal barriers to pain management negatively affect patients' coping efforts (utilization of available analgesics) and consequently patients' QOL.
This is a descriptive, correlational study. Participants are roughly 1000 patients, 18 years and older with advanced cancer in four European countries. Data was collected by research personnel who administered paper and pencil questionnaires. Attitudinal barriers were evaluated with the Barriers Questionnaire-II, pain was evaluated with the Brief Pain Inventory, and QOL with the EORTC QLQ-C30, all widely used, valid and reliable questionnaires. Descriptive statistics will be used to describe attitudinal barriers, in the whole sample as well as for samples from individual countries. Inferential statistics will be used to compare attitudinal barriers between countries and to examine the relationship between barriers, pain, pain management and background information such as age, gender, and disease variables.
Data collection has just been completed and data is being prepared for analysis. Hopefully the results will aid in further studies on patient education interventions to improve pain management in clinical practice.

PE 2.S20

Psychological diagnostic profile of palliative patients

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To know the psychological profile of patients attended by a palliative care team in a teaching hospital. Descriptive analysis carried out by medical records revision. Inclusion criteria: Patients and relatives referred for symptom control between January and June 2008 with psychological distress > 3. Exclusion criteria: Refused psychological intervention; Cognitive impairment; Intervention < 48 hours. Variables studied: Age, Gender, Service from referral, Main diagnosis (CID9); Destination on discharge. Psychological diagnosis (DSM-IV-TR and CID-9-MC in 3 axes. Axis I: Clinical disorders and problems object of clinical attention. Axis II: Disorders of personality. Axis IV: Psychosocial and environmental problems). Descriptive statistics analysis were used.
From the whole sample (N= 333) 153 (46,25%) were evaluated by the psychologist. Main age: 69,6 (25-95); Male:59,76%; Diagnosis: Oncology 92,50%. Destination on discharge: Supportive Home Care Team 30%, Sociosanitary Centers 24,9%, Deaths: 22,2%, others 22.8%. Psychological Profile: 23% presented alterations in axis I: 100% Coping Problems (code 316); and 36,60% Mixed Adaptive Alteration with anxiety or low mood (code 309.28). Alterations in the axis II were found in the 8.5%: 3 Narcissist alteration of the personality (code 301.81) and 3 Histrionic alteration of the personality (code 301.50). Axis IV was affected in the 38%: Conjugal related problems (Code V61.10) in 13 cases and Paternal-filial related problems. (Code V61.20) in 13 cases. The 15,02% presented adaptive non pathological symptoms (no altered any axis).
Conclusions:
1) Patients under psychological supervision presented problems related to coping styles, and misadjusted behaviors.
2) Few patients had problems related to aqxis II and IV.
3) An important proportion of patients and caregivers did not show any pathological symptom.

PE 2.S21

Can practice knowledge inform the development of competencies in the nursing management of terminal restlessness?

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Terminal restlessness is a complex, multifactorial phenomenon experienced by 25%-85% of terminally ill patients in their final days or hours of life, (Bjajtman, 2003). Part of the aim of a larger study was to evaluate education on terminal restlessness. Qualitative and quantitative methods were used to assess nurses' perceived levels of competence in managing terminal restlessness patients. A cohort of 13 registered nurses, working in an Australian palliative care inpatient facility, completed assessments and interviews pre and post education on the topic. Interviews explored the participants' knowledge and experience in dealing with the complex condition.
Extensive literature review revealed a wealth of information defining terminal restlessness, its assessment and management, however the majority of the information was medically focused. Preliminary analysis of interview transcripts identified already well-entrenched nursing strategies for managing terminal restlessness, based on the experience, and knowledge of the participants.
This 'practice knowledge', or 'know-how' (Lumby, 2000; Sutton & Smith, 1995), was incorporated into the educational package as nursing management of terminal restlessness, and subsequently delivered to a wider audience of palliative care practitioners.
Individual interviews and self-assessment scores two months following delivery of the education indicated increased confidence, and a measurable uptake of the 'practice knowledge' by the participants. The results highlighted the need for greater recognition of, and opportunity to nurture nursing knowledge in relation to a frequently experienced phenomenon.
Recommendations for further research would be aimed at validating outcomes across a broad range of palliative care specific sites of care, and developing a base set of nursing competencies which address a complex and challenging area of palliative care nursing practice.

PE 2.S22

Implementing palliative outcome measures in a palliative care unit (PCU) in Argentina

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Introduction: OM are important to evaluate the efficacy of palliative care (PC) interventions, and reveal problems and opportunities for improvement. There is little information available from developing countries. The US National Hospice and Palliative Care Organization (NHPCO) developed a set of End Result Outcomes of Care, including comfortable dying, which is an outcome related to dying free from distressing symptoms for which interventions are available, with pain being the most common and feared symptom.
Objective: Evaluate implementation of comfortable dying as an OM of patients comfort after 48hs of care in a PCU in Argentina.
Methods: All consecutive patients at first outpatient PC consultation and admitted to hospital general ward or acute PCU, from Sep 2007 to Aug 2008, were assessed of the presence of pain. Patients with affirmative answers were reassessed within 72hs after the first 48hs of admission and asked if their pain was brought to a "comfortable level" within 48 hours of admission. Patients without pain or unable to self report were excluded.

Results: 343 patients were assessed; 51% (174) in the outpatient clinic, 42% (146), in general ward, 7% (23) in PCU. 58% (198) were included and 42% (145) were excluded (28% without pain and 14 % unable to communicate). After the first 48hs, 62% (122) were comfortable, 16% (32/198) were uncomfortable because of pain and 22% (44/198) were unable to self report.
Discussion: The use of this OM of quality of care was feasible in different settings of care in a developing country. The percentage of patients comfortable with pain level was similar to those reported by the NHPCO. These results are a starting point to define standards of care and quality improvement measures in the future The need of a phone contact 72hs after admission may generate work overload of staff but It allowed us to make corrections to treatment plans immediately and patients were very pleased to have been contacted by team members.

PE 2.S23

Outcomes measures of care in caregivers (CG) in a palliative care (PC) unit in Argentina

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Introduction: One of the aims of PC is family support. This includes training CG to feel more confident in the care of the patient and helping the family member prepare for the death of their loved one. Family perceptions of care are essential in quality improvement initiatives. The US National Hospice and Palliative Care Organization (NHPCO) developed a set of End Results Outcomes of Care that includes family assessment. There is no standardized data on family perception of care available in Argentina.
Objective: Evaluate these key processes of care using NHPCO outcome measures in CG post death.
Methods: Phone contacts to CG of all patients (pts) assisted by a PC team, 2 months after death during 1/Sep/07 to 31/Aug/08.
Three questions were used:
1) did our PC team increase your confidence to safely care for your loved one as death approached?;
2) Did our PC team provide effective emotional support for you in preparing for the death of your loved one?;
3) Based on the care that you and your love one received, would you recommend PC to others?
Possible answers were yes/no. Place of death was also recorded.
Results: 150 pts died. 19% (28) died at home and 81% (122) hospitalized (34% in an acute PCU and 51% hospitalized with PC assistance).In 28% (41) no phone contact was possible. Of those contacted 87% (93/109) felt more confidence to care their love one, 84% (90/109) felt they received emotional support that helped them to prepare to the death of their love one, and 96%(102/109) would recommend PC to others.
Discussion: Most of the CG reported positive answers related to PC interventions, despite the fact that almost a third could not be contacted. Negative answers were found mainly in patients where the follow up was short, only during hospitalization, and where contact with the caregiver was very limited. Most pts died hospitalized receiving specialized PC support, as there was no home care available. These results allow future quality improvement interventions.

PE 2.S24

Health professionals' views and use of the Edmonton Symptom Assessment System in the care of patients with advanced cancer

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The Edmonton Symptom Assessment System (ESAS) is a useful tool to assess patients in palliative care. It was introduced by the Palliative Care Team in a hospital 3 years ago. The study aimed at assessing oncology and palliative care health professionals' view of the tool and their use when caring for patients with advanced cancer. A questionnaire was developed and used on a face to face interview with health professionals of 2 wards caring for oncology patients. The sample included: nurses (n=13), nursing assistants (n=4), physicians (n=10) and the palliative care support team (n=5). Descriptive analysis was conducted and content analysis of the open-ended questions. 74% of Oncology health professionals had heard about ESAS but recognized never having consulted it. They initially commented it did not contribute much to their practice. However after seeing the tool and a case, all the professionals stated that it could add much to improve the symptom control, quality of care and the follow up. Palliative Care members used the ESAS in the daily practice and considered it useful. 40% of these professionals do to each patient at least one ESAS per day and the same percentage one per week. They unanimously considered convenient to do to each hospitalized patient one ESAS everyday or every two days; while 80% suggested carrying out the ESAS in each outpatient visit. The open-ended questions pointed out some difficulties with the terminology and with the lack of time. The suggestions to promote the use of ESAS were: to announce the ESAS through pamphlets and information sessions and to promote its use introducing a more accessible computer icon. Oncology health professionals did not know the ESAS in deep but considered its regular use would add much to improvements in the quality of care of the patients. An implementation plan could help to obtain more clinical impact of the ESAS.

PE 2.S25

A multi-centre validation study of two numerical rating scale versions of the Edmonton Symptom Assessment System (ESAS) in palliative care (PC) patients (PTS)

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Aim: The ESAS is a widely used tool for self-reporting of symptom intensity by PC PTS. It consists of numerical rating scales (0=no symptom, 10=worst possible symptom) for 9 common symptoms, with the option of adding a 10th. A recently completed prospective "think-aloud" study of 20 advanced cancer PTS identified potential areas for improving the ESAS. The ESAS was revised accordingly (ESAS-r). Changes included emphasizing the timeframe as "now", adding brief definitions for potentially confusing terms, grouping related symptoms together and moving "well-being" to the end. The objectives of the current study were to compare PTS' responses between the ESAS and ESAS-r, and obtain their opinions regarding ease of understanding and completion of these 2 versions.
Methods: English-speaking PTS referred to PC programs (tertiary PC unit, hospice, acute care consultation service, outpatient clinic) in 4 cities were recruited using cross-sectional sampling. Consenting PTS completed the ESAS and ESAS-r, and were asked structured questions to elicit their opinions of these 2 versions.
Results: As of October 2008, 464 PTS have been screened; 60 PTS out of a target sample size of 160 have been completed (male 52%, mean age 61.5 (SD 13.6), lung cancer 25%, genitourinary cancer 18%). Mean ESAS scores ranged from 1.5 (SD 2.3) for nausea to 4.5 (SD 3.3) for appetite. Mean scores differed between the 2 versions by less than or equal to 0.2 for all symptoms except appetite (ESAS-r 3.7 (SD 3.4)). 65% and 73% of PTS rated the ESAS and ESAS-r as either very easy or easy to understand, respectively. 78% and 83% of PTS rated the ESAS and ESAS-r as either very easy or easy to complete, respectively. 10 and 22 PTS preferred the ESAS and ESAS-r, respectively; 28 PTS had no preference.
Conclusion: Preliminary data suggest that PC PTS find the ESAS-r easier to understand and complete than the ESAS. More PTS prefer the ESAS-r than the ESAS.
Funded by CIHR PainNET.

PE 2.S26

Palliative care needs assesment in Republic of Moldova

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Needs assessment is the first step of a national strategy. Different methods can be use up to available resources. This needs assessment was done in 2006-2007 by combining an population-epidemiological approach, a SWOT analyses of the three elements of the WHO triangle, questionnaire to the palliative care providers and interviews with key authorities. The country is predominantly rural 61%. There is a social transition (increase divorce rate, decreased marriage, etc) high migration of young adults questioning the resource of carers for potential PC homecare services. From mortality data an estimation of 23567 patients would need annually palliative care (over 50% concentrated in 11 districts and capital-eventual starting points for developing services).
Staff: 143 doctors and 684 nurses specialised in PC would be needed to care for the identified patients. There is a remarkably high incidence of liver diseases third place in mortality after cardiovascular and cancer. Death occurs home 83.9% (heart diseases, cancer, liver failure, trauma) and 16.1% in hospital (stroke, septicaemia, hearth attack, AIDS, TB). There are potential beneficiaries for PC in each group so basic PC training should be included in the curriculum for nurses and targeted medical specialities. Guidelines and protocols are needed. From the 9 providers in the country 1 fully engaged in PC other 4 devoting over 50% of time to PC. Work is heavily relying on volunteers.
Types of patients cared for: cancer, AIDS, Cirrhosis. Average of stay in service: between 30 days and 6 months. Financing no public sources. Existence of 2 national PC associations shows lack of maturity. No official recognition for PC, no oral opioid available, over restrictive regulation concerning opioid prescription but PC included in the national health policy, provision in the frame contract but no contracting modality stipulated, task force for PC created officially. Results presented to authorities.
SOROS founded project.

PE 2.S27

Building local capacity and sustainability in hospice and home based care - A study of hospice and palliative care services in South Africa

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The vision of the Hospice Palliative Care Association of South Africa (HPCA) is Palliative Care for all. One of the strategies to achieve Palliative Care for all is to develop a hospice or palliative care service in every health sub - district. Hospices alone can not achieve this and therefore home based care organisations are developed to enhance the services they provide by incorporating Palliative Care into the service. To enhance services an in depth study of the service must be conducted. To conduct assessments and build capacity assessment tools were developed by the organisational development section of the HPCA.
The purpose of the tools were
a) to assess organisational capacity,
b) to identify capacity building needs,
c) to give recognition to achievements of the organisation,
d) to provide appropriate Palliative Care training,
e) to provide organisational mentorship and
f) to share and continue the hospice philosophy.
86 Organisations in 9 provinces with the potential to incorporate Palliative Care were included in the programme and underwent assessments which was followed by the implementation of development plans. Capacity building was done by a team of people with a variety of Palliative Care and other skills. The result was not just better developed organisations with Palliative Care added to the service but also an organisation which is credible and sustainable. In four of the nine provinces these organisations were able to diversify their funding sources significantly. The main aim of all of these activities were to improve service and give quality care to patients and families.
The purpose of this presentation is to share the assessment tools, the process used, lessons learnt, share successes and make the assessment tools available to other organisations wanting to expand Palliative Care and enhance programmes other than hospice and Palliative Care services.

PE 2.S28

Therapeutic relevance of non-invasive diagnostics in palliative care - results from a representative survey and own experiences

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Introduction: Applying diagnostic techniques in palliative care (PC) requires a thorough balance between a physical, psychosocial (and financial) burden and its therapeutic relevance in far advanced diseases. The extend of diagnostic employment in PC, preferred techniques, application problems, its informative value and therapeutic significance still have to be described.
Methods: The Hospice and Palliative Care Evaluation HOPE 2007 accrued the application of microbiological and imaging techniques in PC institutions. Furthermore, 70 consecutive ultrasound scans in our PC unit have been retrospectively assessed.
Results: In 691 PC patients (from a total of 3184 in HOPE; 21,7%), diagnostic techniques (DIA) were applied and documented. In-patients with DIA (86,1%) and the HOPE collective showed a comparable age (67,9a) and duration of hospital stay (16,9d). Microbiological techniques contributed to 26,1% of all documented in-patient investigations, imaging techniques 69,1%. Ultrasound was the preferred imaging technique on PC units (41,3%), whilst radiography was rather employed on oncology wards (OW, 38,6%). CT / MRI (16,6% on PC units, 19,3% on OW) and nuclear imaging (1,9% on PC units, 7,0% on OW) were rarely documented. In 88,4% resp. 80,8%, DIA was considered relevant for further treatment decisions (in-patients only); transportation problems and pain during imaging were relevant obstacles. In our own patient cohort, ultrasound was followed by therapeutic changes in 37,2%, mostly invasive procedures (17,1%). Transportation problems could be almost entirely avoided by using a mobile ultrasound device.
Discussion: DIA in PC is applied independently of age or duration of hospital stay; its therapeutic significance is considered to be high (resulting in active therapeutic measures or general prognostic reevaluation); procedural problems may be resolvable. Therefore, this survey might challenge the tradition of low technology in PC.

PE 2.S29

Computer assisted tool for documentation and quality assurance in pain and symptom management in palliative care patients (QUAST Palliative Module)

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Aim: QUAST is the validated German pain therapy documentation system for use of pain clinics and pain specialists. An expert group of the German Chapter of the International Association for the Study of Pain (DGSS) developed an additional documentation module for palliative care patients in order to facilitate entry of complex information with regard to pain and symptom management in this patient group. The aim of the development of the QUAST Palliative Module (PM) was to present a valuable tool for daily documentation of patients' treatment and for outcome studies in Germany.
Methods: QUAST PM has been developed on the base of File maker Pro, a user-friendly and analysis-oriented database environment for QUAST documentation and quality assurance. The module comprises: an outcome questionnaire for the evaluation of treatment-related changes of outcome variables, a daily questionnaire and a protocol for treatment procedures and effects of symptomatic therapy, including nursing measures, physiotherapeutic interventions and psycho-social procedures. The documented data of patients can be analysed, printed, and automatically assigned to coding systems like ICD-10 or ICP-M.
Results: QUAST PM has been tested by 4 Centres for Palliative Care in Germany by entry of data of more than 250 in- and outpatients. Compared to previous documentation on paper QUAST PM proved to be user-friendly and resource-effective. QUAST PM is compatible with the core data set documentation requirements of the annual nation-wide documentation system (Hospice and Palliative Care Evaluation Group (HOPE)) in Germany. Furthermore, QUAST can be used as performance record for statutory health insurers and for scientific and health services research. Detailed examples for use will be presented.
Conclusions: QUAST PM facilitates excellent documentation for various purposes (quality assurance, research and remuneration) and settings (in- and outpatient).

PE 2.S31

Development of assessment tool for terminal cancer patients

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Objectives: Since the number of patients with advanced cancers is increasing gradually, it is very important to control their various physical and psychological problems. In order to control the symptoms effectively and improve the patients' quality of life, it is essential to find and evaluate precisely the various symptoms of terminal cancer patients. We have developed the symptom assessment tool for terminal cancer patients, and compared the results of the assessment with patient reported outcomes.
Methods: We evaluated 17 common symptoms shown in patients with terminal cancers. Patients' symptoms were scored as none(0), mild(1), moderate(2), or severe(3) with reference to objective criteria. The records of the physical symptoms were carried out on the similar hour every day. Among the patients, who have clear consciousness and can communicate normally, were investigated in order to evaluate the severity of common symptoms by using Memorial Symptom Assessment Scale (MSAS).
Results: The physicians performed evaluation of 121 terminal cancer patients by using the assessment tool and history records of physical examinations as well. Only 54 patients could be investigated to evaluate the symptoms by using MSAS. The physical symptoms have no difference in the evaluation results between the patients and physician. The physicians' evaluations on drowsiness, nervousness and anxiety were significantly different in terms of frequency, severity and distress. (p=0.0001, 0.0001, 0.005).
Conclusions: The patients who were reported the outcomes by using MSAS could be obtained from 44% of the patients with terminal cancers. However, the tool used by doctors to evaluate objectively could be applied for all patients including who cannot communicate every day. Compared to the actual reported symptoms, the symptoms evaluated with the tool showed less seriously, especially in psychological symptoms.

PE 2.S33

Monitoring the effect of palliatieve sedation: a systematic review

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Background: Palliative sedation (PS) is an important intervention for relief of refractory symptoms at the end of life. To assure the proportionality of PS, adequate monitoring during of the effect of PS is essential.
The goal of the present systematic review was to evaluate use of measurement instruments for the effect of PS in current literature.
Methods: Following the PICO method, studies published between 1991 an 2007 evaluating PS written in English, German or Dutch were identified using Pubmed, EMBASE, Cinahl and the Cochrane library. Prospective as well as retrospective studies, guidelines and reviews were considered for inclusion. Data were extracted concerning the manner in which the effect of PS was monitored.
Results: The search yielded 245 studies of which 12 articles could be included. Cited reference search revealed 8 additional studies. In pro- and retrospective studies (n=9), effect of PS was monitored by way of assessing the level of (refractory) symptom control (n=7), monitoring the level of consciousness (n=5), monitoring of vital parameters (n=2) and level of patient comfort (n=1). Predominantly ad-hoc instruments were used, established measurement instruments were used in 3 cases. Guidelines and reviews (n=11), explicitly referred to the use of specific instruments or observation methods in 2 cases.
Conclusion: Monitoring the effect of PS has been conducted in different ways in PS literature. The use of reliable and valid measurement instruments appears to be limited. In order to improve the quality of palliative sedation, use of and research in monitoring instruments for the effect of palliative sedation should be increased.

PE 2.S34

Assessment of knowledge, attitudes and practices in end-of-life care

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Aims: A cross-sectional study was conducted to describe the relationship of the resident physicians´ knowledge, attitudes and practices in end-of-life care and demographic features, medical specialty, formal training on care of the dying, personal and clinical experience on care of the dying patients.
Materials and methods: A total of 67 resident trainees participated and answered the Knowledge-Attitudes-Practices (K-A-P) questionnaire on end-of-life care. The data gathered were tallied using Microsoft Excel and analyzed using SPSS 10.0 statistical software.
Results: More than half of the respondents have adequate knowledge (52.2%), positive attitude (53.72%), and have appropriate practices (53.7%). Nearly half (49.3% and 44.8%) scaled themselves as satisfactory in knowledge and attitudes; a third (38.8%) assessed themselves as satisfactory in practices. Using Chi-square test, there were no observed significant associations when the relationship between the different physicians' characteristics and their knowledge, attitudes, and practices was assessed. For knowledge, ENT-HNS, Family Medicine and Surgery residents had the most residents with adequate knowledge (p = 0.055). For attitude, Family Medicine, Obtetrics-Gynecology and Surgery had the most residents with positive attitude (p = 0.156). For practices, Family Medicine, Child Health and Surgery had the most residents with appropriate practices (p = 0.010). Those with personal experience with death of a loved one or a close friend (61.2%) had appropriate practice in end-of-life care than those without (33.3%) (p = 0.042). Lastly, residents who rated themselves as either having a very satisfactory and satisfactory knowledge, attitudes and practices in end-of-life care had higher proportion of actual adequate knowledge, positive attitude, and appropriate practices (p = 0.001 and 0.016 respectively).
Conclusion: This preliminary study described the relationship of the resident physicians´ knowledge, attitudes and practices in end-of-life care and physicians´ characteristics. The results were utilized as basis for ongoing planning of the supportive, palliative and hospice care training and education programs in the institution.

PE 2.S35

Constipation - How to audit practice against standards

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Background: A Palliative Care Network based in Northwest England has evidence based standards and guidelines for the management of constipation. Standards should be adhered to when managing constipation, but measuring practice against these standards it is not always easy to do.
Aims: To assess the management of constipation across the Palliative Care Network and surrounding areas against the regional standards.
Method: During November 2007 a multi-centre multi-disciplinary prospective survey was performed. A questionnaire was completed for 10 consecutive new referrals by every specialist palliative care inpatient, hospital and community team in the study area. It asked about bowel function and medications on initial assessment (day 0), days 3 and 7 and aimed to measure

current practice against the existing standards. E.g. "Patients commencing strong opioid therapy should also be started on a combination laxative. (Grade D)".
Results: 226 patients were included. 94 patients did not have bowel trouble. Of the129 with bowel trouble; 89 had constipation alone, the rest a combination of constipation, diarrhoea and incontinence.
50 patients dropped out by day 3, mainly due to patient death or transfer to a different care setting.
Opioid use increased from (121/226) 53.5% on day 0 to (122/176) 69.3% on day 3 and all laxative use increasing (121/226) 53.5% to (118/176) 67%. Despite this increase the trend was not to start a combination laxative for opioid induced constipation, with one third taking opioids on a combination laxative.
Conclusion: It is clear that to measure practice against evidence based standards:
1. The strong evidence base that should support good standards is not always there.
2. Clear and measurable standards are difficult to write.
3. Measuring practice against standards and producing accurate results can be difficult even when standards are well written.
Following this study and literature review the standards and guidelines for the network were revised.

PE 2.S36

Intention to leave: A hospice problem?

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Premise: Nurse turnover is a costly problem for hospitals. Job stress work satisfaction group cohesion and weekend overtime were all predictors of anticipated turnover (Shader 2001). Vachon (1995) attests that staff stress and burnout in hospice/palliative care is less than in other settings but that this stress is due mainly to organization and social issues.
Aim: To audit the "intention to leave" in a Western European country hospice.
Method:
Sample: full time nurses and nursing assistants of Vidas hospice. Nurses and nursing assistants were defined as registered or licensed practical nurses. The hospice opened in 2006, the audit was carried out after 2 years of activity.
Instrument: semistructured individual interview given by an outside psychologist consisting of 20 questions and an anonymous questionnaire. Items structure was established using a resource expert and international literature review.
Results: Hospice staff at start up: 5 white non Hispanic and 1 Hispanic nurses; 8 Hispanic and 2 white non Hispanic nursing assistants. Sex: 4 M; average age 40. 25% had previous experience in palliative care. Hospice staff in 2008: 5 white non Hispanic and 1 Hispanic nurses, 12 Hispanic nursing assistants. (# 18) Length of stay on the current job ranged from 7 to 24 months, average stay: 21.6. (# 19) 1 planned to leave, and 2 said they were looking for another job. Most consider the job exciting (# 9), and a chance for personal growth (# 8), but for 2 nursing assistants professional exchange is low (# 3), and for 2 nurses and 1 nursing assistant the knowledge development is average (# 7).
Conclusion: The interview showed the extrinsic factors that need to be analyzed to identify turnover risks. Instead the anonymous multiple choice questionnaire inquired into the intrinsic factors of the turnover. The full analysis will help identify the factors which influence the intention to leave and will allow us to implement better operating strategies to retain competent nursing staff.

PE 2.S37

Are referrals to the specialist palliative care team influenced by the team's presence at multi-disciplinary meetings?

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Aim: We reviewed the number and nature of referrals of patients with different tumours to the Specialist Palliative Care Team (SPCT). The information is compared to Scottish mortality data detailing numbers of deaths from cancer to assess whether the presence of SPC at team meetings influences referral patterns.
Method: Data is collected on patients referred to the SPCT, including diagnosis, reasons for referral and results of initial assessment. Microsoft Excel has been used to describe the data.
Results: There were 830 episodes of patient care from January 1st to December 31st 2006. Most common causes of death from cancer in Scotland, 2005: lung, colorectal and breast. Referrals to SPCT were most frequently received for patients with cancer of lung (16.4%), head and neck (12.5%) and breast (12.2%). Majority of referrals requested symptom control (93%). Other reasons given: psychosocial support (14.3%), future care planning (8%) and end of life care (1.8%). Patients with lung cancer were more likely to be referred for psychosocial support than those with breast cancer (18% v 10%).
Conclusion: The cancer hospital in which this project was carried out provides oncology services for 60% of the Scottish population. The Specialist Palliative Care Team (SPCT) at the cancer centre is an advisory team with varying input into site-specific oncology teams. SPCT has regular attendance at multidisciplinary team meetings (MDTMs) for lung and head and neck cancer. Attendance at site-specific MDTMs appears to influence referral to SPCT. Variation in reason for referral may reflect understanding of SPCT role and symptom burden of tumour type.

PE 2.S38

24-hour specialist palliative care advice line: An audit of the first 5 years

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Out-of-hours (OOH) telephone support has been part of services provided by a specialist palliative care unit (SPCU) to patients for many years. In 2002 it was decided to open the service to all patients within a wide geographical area regardless of whether they had received care at the SPCU.
Method: A 24-hours telephone support line was formally established. SPCU staff undertook call-handling training. The service was promoted to healthcare providers and patients. Calls were handled by the nursing/medical team on duty. A senior SPC doctor was available for complex symptom management referral. Data on all calls was collected and categorised: status of caller, nature of call, time of call, location of patient and advice given. As a quality control measure a survey of service users was undertaken.
Results: 2,872 calls were received OOH, 216 in 2002 to 684 in 2007. Calls requested symptom management advice (47%) drug advice (17%), admission requests (11%) and nursing advice (8%). Non-clinical general enquires accounted for 16% of calls. Patients/relatives were the major users of the service (62%) followed by nurses (27%) and doctors (11%). Most calls were from the patient's home (74%) followed by hospitals (20%) and other community settings (6%). Service users came from 20 Primary Care Trusts. On-going evaluation by subsequent telephone interview shows that 94% of users found the advice given useful. 92% of calls were resolved and/or an appropriate referral made. The need to contact another OOH provider was avoided in 44% of cases.
Conclusions: The service provides a highly valued resource to patients/carers and HCP requiring symptom management and/or drug advice OOH. The collaborative and holistic approach ensured that symptomatic patients were afforded appropriate timely advice thus minimising unnecessary suffering.

PE 2.S39

Care audit in the African setting

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Aim: South African Hospices have been using the APCA POS (African Palliative Care Association Palliative Outcome Scale) audit tool with some very positive outcomes. This tool was developed by APCA and validated by Kings College, London. The tool measures palliative outcomes over a period of 6 weeks of receiving hospice care, starting with the very first home visit. Ten specific areas are measured; these include physical, psychosocial and spiritual symptoms.
Methods: Under the auspices of the HPCA's (Hospice Palliative Care Association of South Africa) patient care portfolio, and in line with a grant from the Canadian International Development Agency, the tool was introduced to a group of 50 South African hospices who used the APCA POS to identify areas for quality improvement within their home care programmes.
Results: In terms of results, it is too early to make any comment on the quality of care broadly; but what is already emerging is how very useful the application of the results are at individual hospice level.
Examples of how hospices are making positive management decisions and changes, as well as using the results to select topics for clinical audits, will be shared. Quality management and improvement is one of the service elements included in the HPCA/COHSASA (Council for Health Service Accreditation of Southern Africa) standards.
Conclusion: The APCA POS is fast becoming a key tool for member hospices to use in terms of their own quality management and improvement programmes. Changes in policy and practise can now be weighed up, as subsequent audits reveal their impact on the quality of care.

PE 2.S40

Quality of life of cancer patients treated in Helsinki University Central Hospital, Department of Oncology. A cross-sectional study

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The aim of this study was to investigate the quality of life and the prevalence of symptoms of cancer patients treated in Helsinki University Hospital, Department of Oncology. This study took place in one selected day, 31st of November 2006, when all cancer patients treated in the Department were interviewed by EORTC quality of life questionnaire. 447 patients were eligible for the study. 215 (48,1%) responded to the questionnaire. 129 patients (60%) were female. 40.5% had breast, 20.5 % prostate and 15.3% gastrointestinal cancer. Local disease was present in 119 (55.9 %) and advanced disease in 96 (45.1%) patients. 104 patients (48.4%) had radiotherapy, 98 (46.0%) chemotherapy and 56 (26.4%) endocrine therapy.
Results: The global quality of life (62.0) was somewhat worse in our patients as compared to Nordic population as well as physical function (69.3), role function (69.8) and social function (75.3). Emotional (78.6) and cognitive function (83.2) seemed to be at the same level than in the Nordic population. Fatigue (91.1%) and insomnia (71.2%) were the most common symptom (at least modest in intensity in 37.4 and 19.5% of the patients, respectively). Pain was reported in 55.3% of the patients, at least modest pain in 16.3%. Depression and anxiety was reported by every second patient; loss of appetite, constipation, breathlessness and diarrhoea every third, but the intensity was mainly mild. The quality of life was lower and the symptoms more significant in patients with advanced than local disease except insomnia (at least modest in 17.7 vs. 20.5%, respectively). Pain was most commonly seen in patients with bone metastases (76%) than in other patients (51%).
Conclusion: The quality of life of cancer patients was lower than in the general population, especially in field of physical, role and social function. The most common symptoms were fatigue and insomnia. However, the intensity of the symptoms was mild in general.

PE 2.S41

The "Therapeutics Drug Round" - Improving the quality of hospice inpatient prescribing

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Aim: To audit the effectiveness of the "Therapeutics Drug Round" (TDR) as a means of correcting actual or potential prescribing errors.
Background: Despite the frequent lack of an on-site hospice pharmacist, prescribing in palliative care is thought to be of high quality. In our unit a perceived lack of routine attention to the monitoring of steroid use led to the development of the weekly TDR in which drug charts are reviewed away from the patient but in light of the patient's medical history, prognosis and other relevant factors.
The TDR reviews several aspects of risk recognition and minimization related to prescribing, including: Drug chart legibility; Congruency between the background and PRN (as required) opioid doses; Management of steroids (when started, for what indication, at what dose, with what effect, when to change); Appropriate prescribing of end of life PRN medication; Drug interactions; Appropriate stopping of drugs
Method: Retrospective notes analysis to audit the quality of information documented at the TDR over two time periods in January and April 2008. Data were collected on a proforma and analysed against a set of

standards for the TDR process. Data were also collected to analyse whether prompt (<24 hours) action was taken to correct any prescribing errors identified.
Results: Only 56% of eligible patients' drug charts underwent the TDR process. Six (of 34) charts were identified as requiring a re-write, of which only one was completed within 24 hours. There were two (of 33) instances in which the PRN opioid dose required altering, both promptly corrected. Action regarding steroid use was identified as necessary in 5 of 27 cases, of which 4 were complied with. There was no documented evidence that potential drug interactions were assessed in any cases. Other results will be presented.
Conclusions: The TDR is a useful tool in reducing drug errors. This audit produced a change in management of the TDR process to improve its effectiveness.

PE 2.S42

An audit of antibiotic prescribing in a hospice inpatient unit

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Infections are common in palliative patients, and may cause significant morbidity. Appropriate use of antibiotics can improve quality of life.
Aims: Audit antibiotic prescribing in the hospice inpatient setting.
Methods: Retrospective casenote audit of 75 consecutive admissions to inpatient unit, examining frequency of oral/parenteral antibiotic prescribing, indications for antibiotics, use of laboratory investigations, antibiotics used, duration of treatment, record of response and outcome. Prescribing was compared with local trust guidelines.
Results: 19 of 75 admissions resulted in antibiotic prescription(25.3%). 1 patient recieved antibiotics on 2 separate occasions during admission. Malignant and non-malignant disease groups were represented. Urinary tract infections(including pyelonephritis) were most common(60%), followed by pyrexia of unknown origin(15%), chest infections(10%), cellulitis(10%) and malodourous wounds(5%). Symptoms suggestive of infection were well documented(95%). Appropriate laboratory samples were obtained in 65% of cases. Trust prescribing guidelines were followed in 45% of cases. Reasons for non-compliance were poorly documented, but included suboptimal dosing, alternative antibiotic indicated by culture results and need for alternative formulation of antibiotic. Intended duration of treatment was recorded in only 4(20%)cases. Antibiotics were changed during treatment in 3(15%)cases. Record of response to treatment was poorly documented. 75% completed an appropriate course of antibiotic, 25% had the course discontinued due to deterioration in general condition.
Conclusion: Antibiotics are frequently used in the hospice setting. Local trust guidelines for prescribing are adaptable to the hospice setting, and duration of treatment should be considered in advance. Reasons for treatment, and response to treatment should be documented. Hospice specific guidelines have been introduced to improve practice.

PE 2.S43

Audit of inpatient prescribing by clinical staff on the inpatient unit

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Aims:
1) Assess adherence to prescription guidelines by prescribing staff on the Inpatient unit
2) Review & update *Guidelines For Prescribing on the Inpatient Unit*
3) Assess adherence to standard operating procedures for prescribing support by pharmacists
Methods: The first 25 patients admitted to each inpatient unit during July 2007 were identified and notes collected (n = 42). The standards below were audited.
1) All prescription guidelines adhered to (A to M)
2) Inpatient guidelines meet current national prescribing guidelines
3) Pharmaceutical assessments carried out on admission or when pharmacist next on duty
4) Anomalies between pharmaceutical assessment and drug chart are brought to the attention of the doctor and documented.
All standards were to be achieved at 100%, except where the guideline was not applicable, e.g. no IV drugs prescribed, and was therefore excluded.
Results:
A: Identifiers present 98%;
B: Patients name on inside of chart 100%;
C: Drug entries in capital letters 50%;
D: Frequency, route, date, signature 100%;
E: Allergies 100%;
F: Chart number 83%;
G: Cross out dose changes, rewritten clearly 100%;
H: Discontinue with date & initials 57%;
I: Indications written in notes 76%;
J: Duration of syringe driver 92%;
K: IV drugs written 100%;
L: Verbal orders by two nurses 100%;
M: Verbal orders countersigned & written on drug chart 73%.
Of the 13 guidelines, 6 followed national guidelines, 6 were unique to the hospice but complemented national advice and one contradicted national guidelines. Standards 3 and 4 were met in 76% and 71% of cases respectively.
Conclusion: Overall adherence was good with one notable exception - drug entries in capital letters.
We recommend:
1) guidelines changed to legible writing
2) guidelines changed so abbreviations & decimal places not acceptable
3) anomalies must be recorded on pharmacy form even if information elsewhere in notes
4) clinical staff to re-read guidelines & display copy in doctors' office
5) re-audit in 1 year.
Source of funding: In-house

PE 2.S44

Audit of patient´s transfer letters on admssion to a specialist palliative care unit

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Introduction: All patients should receive a transfer letter on moving from one institution to another as a standard of care, as this forms the principal communication between hospital and hospice-based doctors. Patient transfer is important in the effective coordination of services throughout the healthcare system, but it is not always a straightforward process. High variability exists in terms of the content of transfer letters and they often lack structure and clarity. They frequently have a biomedical focus, omitting vital psychosocial details. We noted that a number of patients admitted to our unit did not have an accompanying transfer letter and the letters that did accompany patients,lacked many details required to admit the patient and necessary for the provision of ongoing care.
Aims: To evaluate the level of information in letters accompanying patients on admission to a Specialist Palliative Care Unit.
Methods: We retrospectively reviewed random charts of patients admitted to our unit. Transfer letters from 20 charts were obtained. The data was retrieved and collated in a standardised format.
Results: Twelve of the 20 charts reviewed had accompanying transfer letters. Eleven (55%) gave the patient's primary diagnosis, 8 (40%) a list of co-morbidities and 11 (55%) a list of current medications. No letter made reference to the patient's level of functioning,support network or insight into the illness and none made reference to follow-up plans.
Conclusion: There are significant deficits in the quality of information contained in transfer letters,with a paucity of psychosocial details in particular. This poor communication we feel, compromises patient care. We aim to draft a transfer document, which we will advise the primary referring team on how to complete appropriately, and this will be required to accompany patients on transfer. We hope that this will improve communication between institutions and ultimately serve to improve patient care in our unit.

PE 2.S45

Analysis of nursing documentation at palliative care ward

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The issue of nursing care documentation is an area of huge discussions concerned with the quality of nursing care management and improvement.
Aim: Analyse and evaluate the quality of nursing records kept at hospital palliative care ward from the point of content and formal perspectives.
Method: The nursing records were analysed by the structure of nursing process phases within the frames of Slovak law. The number of 30 nursing records was taken to the sample of research study.
Results: From the content point of view the nursing records analysed proved that construction of documentation contributed to absence of holistic approach and records demonstrated poor use of evaluation instruments. The nursing diagnosis determination was based on relevant data in majority of records. All the possible spectrum of diagnostic domains of NANDA - International Taxonomy II. was not projected into nursing records analysed. Nurses were oriented to diagnose mostly the same problems arising from the medical diagnosis not from individual approach to the patient. We consider being insufficient if psychological, social and spiritual needs of patients are missed in records. Minor errors and deficits in the field of goals and outcome criteria formulation were identified as well. The evidences of systematic reevaluation of patient´s problems together with subsequent care plan modification were missed in nursing records. Identical results were presented in the papers of more European researches concentrated on the same topic of interest.
Conclusion: Appropriate documentation is more than only the list of patient´s problems and needs. It represents evidences whether at least standard nursing.

PE 2.S46

Antibiotics in palliative care - Results from the HOPE 2006 evaluation

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Background: The use of antibiotics in palliative care is discussed controversially. On the one hand antibiotic therapies are considered essential for symptom control, on the other hand they often seem inappropriate and aggressive. In an epidemiological study funded by Deutsche Krebshilfe (DKH) the research workgroup of Deutsche Gesellschaft für Palliativmedizin (DGP) collected data on diagnosis, therapy and course of disease of palliative patients with infections for a period of three month during a phase of a Hospice- and Palliative Evaluation (HOPE) 2006.
Method: By a specifically developed questionnaire on the use of and indications for antibiotics, decision making on therapy and withholding or withdrawing of therapy were collected.
Results: In 47% of the N = 655 data sets with an optional indication for antibiotics the therapy was administered, 10% registered withholding and 32% withdrawal. The most frequent reasons for withdrawal were: reduction of overall status (9%), death (9%), inefficiency (5%) and patients´ wishes (4%). The beginning of therapy often underlies only the physicians´ decision competence. Withholding and withdrawal obviously needs also the support of the palliative care team.
Discussion: The success of antibiotic therapies seems to be difficult to review, because there are 49% missing data which may due to missing outcome parameters in the context of palliative treatment concepts. In cases of continuation of antibiotic therapies until death, indications are missing, so that a prolongation of the dying process might be discussed. While the start of an antibiotic therapy is often decided by physicians solely, decisions processes resulting in withholding and withdrawal are discussed in the team which might be a hint on high sensitivity in taking responsibility.

PE 2.S47

Audit of major heamorrhage across hospice, hospital and community care settings

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Introduction: Major haemorrhage occurs in less than 10% of patient with advanced cancer. Consequently many health care professionals will not be familiar with the management of these catastrophic incidents. Little evidence exists regarding the management of this life

threatening event.
Aim: To examine the management of potential and actual major haemorrhage in the hospice, hospital and community care settings and develop regional guidelines.
Method: A survey of hospice, hospital and community palliative care teams was undertaken to establish the incidence of exposure of Health Care Professionals to patients who have a major haemorrhage and to ascertain current management strategies. A questionnaire was used to identify episodes in each of the care settings. Respondents were asked to describe the management of patients who were at risk of having a bleed and those actually having a major haemorrhage.
Results: Seventy four health care professionals responded from across the 3 care settings. Thirty four (30%) respondents reported having managed a patient having a major haemorrhage in the last 5 years. The most common diagnoses amongst this group of patients were head and neck (21%), lung (18%) and gastro-oesophageal (18%) cancer. All these patients died within 1 week of the event. In 47% of these patients, the possibility of haemorrhage had been discussed prior to the event. All respondents described the management of patients at risk of haemorrhage. Interventions used included the use of supportive measures and sedation with Midazolam being the most commonly prescribed medication.
Conclusion: Although rare, it is important to plan for potential catastrophic haemorrhage, including the prescription of appropriate sedation. Simple measures also have a role to play. Using the results of the survey, regional guidelines were developed to guide health care professional in the management of potential and actual major haemorrhage.

PE 2.S48

Bowel Management: An audit of recorded bowel management practice

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Aim: Constipation is recognised as a major problem for the palliative care population. This audit is the first step to identify the strengths and weaknesses of how bowel care is assessed and managed. Ultimately the aim is to utilise the results to evoke reflection and assist in the development a comprehensive bowel assessment tool to assist practice.
Method: A retrospective chart review was carried out on 57 patient charts (1/3 of the patient population). The review covered a one month period. Charts were reviewed from
• 43 Specialist Palliative Home Care patients
• 12 in-patients in Specialist Palliative Care Unit
• 9 Day Hospice patients.
Some patients were under more than one service during the month of August.
Results: 75% of these patients were prescribed analgesia. 63% opiate analgesia.
• 26% of patients were not recorded as taking any laxative.
• 33% were taking 1 laxative
• 30% were taking 2 different laxatives
• 11% were taking 3 different laxatives.
There were 6 different laxatives prescribed in varying doses.
• Polyethylene glycols (56%) of those on laxatives
• Docusate sodium (34%)
• Senna (27%)
• Lactulose (20%)
• Magnesium Hydroxide and Liquid Paraffin (13%)
• Ispaghula Husk (4%) patients were on it prior to illness.
How bowel activity was recorded and the management actions were tabulated. The results from each service area were analysed individually.
Conclusion: The results have facilitated unit wide reflection on how bowel care is managed. It was clear from the results of clinical areas where bowel assessment tools were used, although not comprehensive, facilitated a higher quality of assessment. The next step is to develop a more comprehensive but user friendly bowel assessment tool.

PE 2.S49

Withdrawn but not forgotten: Improving palliative care in intensive care

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Background: The Liverpool Care Pathway (LCP) was developed to care for cancer patients and address the needs of the dying. It has been expanded to non-cancer briefs, recently modified for use in intensive care units (ICU).
Aim: To standardise delivery of optimal and personal palliative care in a general ICU through auditing current practice and introducing the LCP.
Methods: A multi-disciplinary team (MDT) reviewed existing LCP documentation, adapted for patients in ICU. The documentation was used to facilitate a retrospective audit of care received by 20 consecutive patients, in whom a decision provide end of life care had been made, after recognition that further aggressive treatment was futile. The audit assessed performance at 3 key stages; initial assessment, ongoing care and after-death care. Within each of these stages, 4 domains were examined: physical, psychological, social and spiritual. The results of the audit were collated and sent to Liverpool for analysis and feedback. Education followed and the results were presented to all ICU staff. The LCP was launched and champions identified to provide on-going education and support for all ICU staff.
Results: In each of the key stages examined deficiencies were noted. Symptomatic relief was well provided. Pre-emptive prescribing to treat pain and dyspnoea was present in 85% and 75% respectively. Families were well informed, 95% understood that their relative was dying. Measures to limit medical intrusion to the dying process were poor. Blood sampling occurred in 95% on the day of death. Documentation addressing spiritual needs was absent in 85%.
Conclusion: There are deficiencies in our current palliative care practices. It is impossible at present to say whether these deficiencies are as a result poor documentation or poor care. By using the LCP and standardising documentation within our ICU we will establish where the problem lies and address any barriers to achieving excellence in palliative care.

PE 2.S50

Developing and collecting a minimum data set for palliative care

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No clear data was available concerning quality and provision of palliative care as each service provider was recording and publishing different indicators. A united set of indicators was also needed because there was the political will to establish a national plan based on real figures. Charitable and public service providers united under the palliative care coalition agreed to the project. First year, 2007 a set of indicators was agreed; structural ones to be collected annually at the same date, and process, output and outcome indicators regularly for each patient (concerning type of disease, waiting time, general wellbeing, pain, burden of care for the family, number of visits/type of staff, days in care, place of death). A database was produced and monthly updated with information from providers. Collecting process started difficult, after the first three months a second meeting was needed to motivate people , to go in detail over the definition of each indicator. From Julie 2008 the information flows in regularly. All coalition members except 4 who are in the start up phase sent in the data's after more or fewer reminders. Over 1000 patients entries into the database up to date. There is a part time dedicated admin staff to the project. In Jan 2009 a first analyses of data will be made, presented to the coalition and the global figures also to larger audience. This is an important and challenging project that needs to be ongoing. It provides extremely valuable data's as global national figures (nr of patients care in different settings, workforce in palliative care, potential financial pressure put on the health system if services like home care would be taken on board and paid /visit as we have the total nr visits/year etc) but also data's concerning quality of care as each provider can compare his performance with similar services eventual benchmarking could be initiated.
The project is funded by NHPCO.

PE 2.S51

Study on the value of Plain Film Abdomens (PFA´S) in assessing constipation in palliative care outpatients

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Aim: Constipation is an unpleasant symptom causing distress to many Palliative Care patients. Self reporting of constipation may be unreliable as symptoms may be attributed to disease. Investigation with plain film of abdomen (PFA) may be considered overkill by radiology. The aim of this retrospective audit is to review our use of PFA´S to aid and assist in the optimal management of constipation.
Methods: A retrospective study of all Palliative Care Outpatients´ charts were assessed over a two year period to analyse the number of PFA´S requested; the outcome of the result of PFA´S by radiology and by Palliative Medicine Physicians, and the treatment plan recommended.
Results: 85 patients were referred for outpatient appointments, 29% (25 patients) had PFA´S and 3 patients had repeat PFA´S. Altogether 30 PFA´S were ordered. 85% of films showed constipation requiring treatment, having a direct impact on patient management. 10% had no significant finding and 5% demonstrated sub-acute bowel obstruction.96% had metastatic disease, 24% of patients had colorectal cancer , 16% had pancreatic cancer with lesser percentages having, lung, renal , breast or bladder. 80% of constipated patients were on laxatives and 60% were on opioids. Of radiology reports 55% did not comment on constipation and there was a discrepancy of 45% between Palliative Medicine Physician interpretation of PFA´S versus radiology.
Conclusion: This study demonstrates that PFA´S are a valuable clinical tool in assessing the degree of constipation in our patient group. 85% of patients were constipated requiring intervention. Symptom control was achieved speedily and therefore quality of life improved.
As a result of this audit, more in-depth analysis of the findings may render more valuable information. This audit may assist in ranking PFA´S as a relevent and valuable clinical tool in addressing a symptom that patients´ rank in the top three most uncomfortable symptoms.
CONSTIPATION, moves on!

PE 2.S52

Evaluation of polypharmacy in home care and ambulatory services in a palliative care unit

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Introduction: The main challenge of health professionals in relation to patients in Palliative Care is the control of symptoms that reduce their quality of life. It often requires the use of polypharmacy for this control, and has been associated with adverse reactions to drugs, medication errors, unable to adhere to therapy proposal and increased risk of hospitalization and can be aggravated by age, presence of other comorbidities, in addition to the cancer amending the kinetics of drugs.
Objective: To evaluate the indicators of polypharmacy and indicators of clinical symptoms of patients referred to the home care service and ambulatory service of palliative care unit.
Method: Analysis of data collected from medical prescriptions, from January to May of 2008 of home care and ambulatory service, counting the number of prescribed items and identifying the prescription with higher and lower number of items.
Results: There was observed an average was 4.6 per prescription at home care and 6.6 in ambulatory. Regarding the number of prescribed items, it was observed that prescription with greater number of items was 20 and the lowest was 1 in the home care and in the ambulatory was 17 and 1 respectively. In patients who complained of pain there was a percentage of 34% for the home care and 50.6% for the ambulatory.
Discussion and conclusion: Achieving the control of symptoms in palliative therapy often requires the use of

medicines and involves polypharmacy. The control of pain recommended by WHO as the analgesic ladder with the use of associations such as: non-opioid analgesics, opioids and adjuvant, ranging from joint pain (antidepressants, anticonvulsants, neuroleptics) to support medication (anti-ulcer and laxative), which makes prescription long, justifying the polypharmacy at ambulatory, where there was a higher percentage of patients with pain.

PE 2.S53

Identification of polypharmacy in home care service in palliative care unit

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Introduction: The polypharmacy is defined as the simultaneous use of more than one product, and has been associated with adverse reactions to drugs, medication error, difficulty in therapy adherence, increased risk of hospitalization and drug interactions. Thus avoiding polypharmacy and the process identified as " prescribing cascade ", which is to add a drug for each symptom, is one of the challenges of palliative care.
Objective: To identify the practice of polypharmacy in home care, giving more rigidity in the criteria for the prescription.
Method: We conducted a quantitative study of the requirements of the months of May through October 2007. Quantified those who had more than 7 prescribed medications.
Results: It was preliminarily found that 33.3% of patients have more than 7 prescribed medications, indicating the high prevalence of polypharmacy. The most used drugs were opioids (88.6%), laxatives (69.9%), non-steroidal anti-inflammatory drugs (92.4%), steroidal anti-inflammatory drugs (48.1%) and anti-ulcer (89.9%).
Discussion and conclusion: Considering that 9 million of adverse drug reactions occur every year in the U.S.A., we believe that of all hospital admissions, 25% are stemming from misuse of drugs and 28% from other problems related to drugs, increasing the financial burden of the process. Beside the kidneys damage, the gastrointestinal disorders from the anti-inflammatory utilization, leading to anti-ulcer drug utilization in order to reduce the discomfort of the patient. Considering the pain cancer as one of the most damaging symptoms that affect the patients in the terminal stage, it is no surprise to frequent prescribing of opioids to control this symptom limiting, as well as the use of laxatives for the management of frequent constipation produced. The polypharmacy may be inevitable, but above all, must rely on the vision together of doctors, nurses and pharmacists to carefully evaluate the risk-benefit condition of each patient.

PE 2.S54

Safe disposal of opioids in the community

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Aim: Opioids and other controlled substances are important tools in symptom management. The volume of prescribed opioids has increased significantly since the 1990s when the use of opioids for chronic non-cancer pain was accepted by the medical community. This process has helped many patients around the world to function optimally, however has also created significant problems in regards to controlled substance misuse, abuse and diversion. Our clinical experience in the palliative population has raised similar concerns. In order to raise awareness to this rapidly growing problem, the "Safe disposal of opioids" Multidisciplinary Committee was formed in Alberta, Canada. This committee strives to add to the current scant literature in this area as well as coordinating its activities with other disciplines with similar interests nationally and around the world. We hope to promote a balanced approach to pain management.
Design: An extensive literature search was conducted to identify all relevant information. Data regarding current opioid disposal methods and the major stakeholders were collected from two urban Canadian communities by means of discussions between multidisciplinary health professionals.
Results: We will report on current opioid disposal methods and relevant gaps and barriers in two urban Canadian communities. We have identified the major stakeholders at local, provincial and federal level. We describe our efforts to share the current literature and information with the public and the health care community.
Conclusion: Information in regards to this world-wide issue needs to be disseminated in order to forge an alliance with other similar stakeholders around the world to advocate for policies ensuring safe provision of controlled substances.

PE 2.S55

Profile of the patients retrieved from pharmaceuticals anamnesis of a palliative care unit: A useful tool

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Introduction: One of the relevant activities to Clinical Pharmacy is the pharmaceutical interview or anamnesis, conducted with the hospitalized patients and their primary caregivers. Information obtained through the questionnaire developed at the institution is able to determine the profile of hospitalized patients and their needs in terms of pharmaceutical orientation.
Purpose: To present the profile of hospitalized patients in palliative care unit in June 2008 and the importance of such information to the adequacy of given pharmaceutical guidance.
Method: Through standard questionnaire, was collected information on the patient´s medical records and through interviews with this or with their primary caregivers.
Results: Of the population of hospitalized patients under palliative care cancer, interviewed in June 2008, 70% are younger than 64 years and only 30% are above this age group. Women represent the majority of primary caregivers. Among patients interviewed in the period, the highest occurrence was the head and neck cancers, 40%. As the level of education were interviewed illiterate patients, patients who could read and write, despite not having completed the basic level of education, and patients with high education completed.
Discussion and conclusion: The large number of patients with tumors of head and neck, which at some stage of the disease have to use alternative routes of administration of food and medicines, point to the importance of guidance on the administration of drugs through these pathways. The level of education of patients, also serves as marked out the instruments for pharmaceutical guidance for use at the time of hospital outcome. Knowing the target audience for our attention and make the necessary adjustments to routines already established in the institution strategies are essential to guarantee the rational use of medicines, the accession to pharmacotherapy and the humanization of pharmaceutical care provided.

PE 2.S56

A prospective evaluation of the effectiveness of interventional pain management procedures in cancer pain - A pilot study

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Aim: A quality assurance study to characterise the effect of interventional procedures as evaluated by the short form Brief Pain Inventory (sfBPI), to assess patient satisfaction with overall outcome and service provision.
Methods: Consecutive cancer patients referred to the pain service over 5 months followed up at 1, 3, 6 weeks post-procedure. Outcomes defined: Complete response=pain score of 0, clinical meaningful response=reduction of pain score ≥2 or ≥33% of pre-treatment score, integrated pain and analgesic scores=a reduction in pain score ≥2 with at least no increase in analgesics or a stable pain score with ≥25% reduction in analgesia. Satisfaction was rated on a 4 point scale from dissatisfied to very satisfied.
Results: 19 patients were recruited; 14 met inclusion criteria. Median age 62 and Karnofsky score 70. 18 interventions (72% epidural blocks) carried out; 3 patients underwent >1 intervention. 16 assessments were analysed.
Patients followed up average 9, 22, 44 days post-procedure. 81% had severe pain at assessment (mean worst pain of 8.9 ± 1.2). Post treatment scores significantly reduced to 2.9±3.2, 3.4±2.9 and 3.1±3.2 ($P<0.05$). Further evaluation showed CR 50% / PR 50% , CR 36% / PR 57%, CR 38% / PR 50% at each time point. 6/9, 6/10 and 2/4 of patients showed a response to treatment when evaluated for IPAS.
There was significant beneficial effect across all domains of interference ($p<0.05$). Pearson's correlation coefficients indicated strong relationship between pain and functional interference ($r = .725$ week 1, $r = .831$ week 6). 57% and 21% of 14 patients evaluated were very satisfied and satisfied with overall outcome of intervention. 92% were very satisfied with the service provided.
Conclusion: Observational studies can serve as useful adjuncts to randomised controlled studies to confirm the efficacy of interventions, evaluate outcomes, further plan service development and importantly to guide the design of new trials.

PE 2.S57

Bereaved relatives evaluation of a specialised outgoing palliative care service in Denmark. A questionnaire survey

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Can we learn from bereaved families about end-of-life care in advanced cancer?
Aim: To analyse the experience of bereaved relatives in order to improve quality of palliative care.
Methods: A questionnaire including qualitative and quantitative questions was sent out 6 weeks after bereavement. The relatives were spouses, children or other close relatives. Patients and relatives with <2 contacts to the palliative team and relatives not understanding Danish were excluded.
We asked about 8 different parts in the questionnaire: The contact to the team; The relatives role and involvement in the treatment; The support of the relatives from the team; Shared care in the sickness period; The symptomatic treatment; The bereavement and the time after; Needs for other health professionals; Demographic data.
The team stated criterion for successful answering in the different categories in advance. The answers were not available for the team members during the survey period.
Results: 123 questionnaires were sent out within 12 months in 2006-2007. There were 86 responses (response rate: 72%).There was no significant difference between demographics in responders and not responders.
Answers which partly did not reach the stated goals for success were: The health staff in the team used an understanding language; Information about the patients' condition was given at the right time; Information about the relatives' options for payment during leave; Respect of the relatives' individuality; Coordination between the team and the GP; Coordination between the team and hospice; Information about when the death was near; The relatives feeling prepared for the bereavement; A follow-up talk with the team members after the bereavement.
Conclusions: The methods in this study could identify areas lacking in the specialised palliative unit in end-of-life care and bereavement. The results from the relatives experience were taken into account in the further work in the department.

PE 2.S58

Can the outpatient treatment in palliative care be ensured by the present care providers in Germany?

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Aim: The subspecialisation in Palliative Medicine was introduced in Germany in 2006. The new law on specialized palliative home care (SAPV = Spezialisierte ambulante Palliativversorgung) by mobile palliative care teams was implemented as a right for all patients in April 2007. To assess the quality of palliative care in Mecklenburg-Western Pomerania (Germany), we sent questionnaires to physicians in hospitals and private practices. The results can help to realize SAPV in our federal state.
Methods: With the support of the Board of Physicians in Mecklenburg-Western Pomerania the questionnaires were send to 600 randomly selected physicians in April 2008. They contained 25 questions concerning knowledge, attitudes and skills in palliative care and cancer pain therapy. These questionnaires based on those of two previous surveys in 1997 and 1999. Until today more than one third of the questionnaires have been returned (n=207).
Results: However only half of the physicians has participated in training of cancer pain therapy and palliative care. One third of the physicians have no information about the WHO analgesic ladder. Likewise one third of them express the opinion that narcotics should only be prescribed by specialists. Nearly half of the physicians are uncertain in the use of narcotics because of a lack of experience. Compared with the previous surveys the results did not show significant changes over the years.
Conclusion: The results show lacks of knowledge and the therapy does often not meet the standards of palliative care or cancer pain therapy. Due to our evaluation multiprofessional Palliative Care Teams are needed to implement specialized palliative home care (SAPV) as a standard benefit of the public health insurance, additional to the existing general palliative care. Intensified training of every student and each active physician is a prerequisite.

PE 2.S59

Cardiopulmonary resuscitation (CPR) in advanced cancer patients in a comprehensive cancer center in Czech Republic - Retrospective analysis of decision making in end of life care of 100 cancer patients

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Aim: Asessment of process and documentation of decision making about CPR in hospitalised cancer patients.
Method: Retrospective analysis of medical and nurse charts of 100 cancer patients who died consecutively in a cancer hospital.
Sample: 100 in- patients, aged 61 years (range 24-82), 90 with metastatic, 10 with localised cancer. In 67 patient the transition from tumor oriented to symptomatic palliative approach have been documented. In 33 patients the basic approach and goal of care have not been documented.
Results: From the 100 consecutive deaths, in 11 patients CPR had been started, but all resuscitated patients died within next 48 h. In 89 patient CPR was not attempted. In only 46 of these patients we found in the record explict reason, why the CPR had not been started. In 30 of these patients the clinical state of patient has been described as „terminal“ and this was given as reason not to start CPR. The CPR has been discussed in advance with the patient in only 2 cases and with patient family in 8 cases. Patients described in medical charts as “terminal” had had significantly lower chance to be resuscitated, transfered to ICU in last days of life. “Terminal” patients had significantly higher average dosis of opioid analgesic, anxiolytics and antipychotics in last 3 days of life than those not characterised as “terminal”.
Conclusion: The decision “not to attempt resuscitatation” is in our cancer center in majority of cases unilateral desicion of health profesionals that “CPR is not indicated”. The role of the patient in this process is weak.
The process leading to this of decision is in general very poorly documented and available data show lot of inconsistency in clinical and ethical decision making. The identification of “terminal” character of patient´s condition increase the chance of adequate clinical care at the end of life.

PE 2.S60

Does early palliative care consultation in the emergency department affect hospital length of stay?

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Aim: To determine whether the early initiation of a palliative care consult (PCC) in the emergency department (ED) compared to routine in-hospital consultation is associated with a reduction in overall hospital length of stay (LOS).
Methods: This study was a retrospective chart review of PCC patients seen between November 8, 2007 and August 6, 2008 at a large inner city community hospital in the US. A convenience sample of 30 patients in the ED initiated PCC group (EDPCC) and 31 patients in the hospital floor initiated PCC group (HFPCC) were selected. The primary outcome was the total hospital LOS measured in hours from ED admission to hospital death or discharge. Other outcomes included percent hospice referrals and change in code status from full code to DNAR.
Results: The mean age of the combined group of 61 patients was 70 years (range 57-84, SD 18.1); 62% were women, and 93% were black. The EDPCC and the HFPCC groups (respectively) were comparable in mean age (68.0 vs. 70.9, p=.54), gender (56.7% vs. 67.7% female, p=0.27), proportion transported from the nursing home (43.3% vs. 41.9%, p=0.51), vital signs (systolic BP 116 vs. 115mm Hg, p=0.9), Charlson comorbidity index (7.3 vs. 6.6, p=0.36), and Karnofsky scores (26.7 vs. 22.6. p=0.15). The primary outcome was that the EDPCC had a mean hospital LOS of 6.5 (SD: 5.3) days vs.11.5 (SD: 7.9) for controls (P=0.005). For the EDPCC group, 47% were enrolled in hospice compared to 74% for control (p = 0.026); 30% of the EDPCC group changed code status from full code to DNAR compared to 39% of the control.
Conclusion: PCCs initiated in the ED (compared to hospital floor) were associated with a significantly decreased hospital LOS, but fewer patients referred to hospice. Further studies are needed to assess whether ED initiated PCCs are associated with shorter hospital LOS.

PE 2.S61

EMG frequencies changes in cancer related fatigue

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Aims: Impaired neuromuscular junction transmission function and central activation failure occur in cancer related fatigue (CRF). EMG frequency reflects afferent feedback inhibition and central modulation. We hypothesized that muscle EMG signals during sustained sub-maximal contraction (SC) in CRF would differ from normal individuals The purpose of this study was to evaluate EMG power frequencies recorded during a prolonged muscle contraction and determine the level of muscle fatigue in CRF and healthy controls.
Methods: Twelve patients (56.3 ± 12.4 years old) with advanced solid cancer (lung, breast and gastrointestinal cancer) and CRF, and 12 age- and gender-matched healthy controls participated in the study. CRF was assessed by having the subjects respond to the Brief Fatigue Inventory (BFI). Surface EMG signals were recorded continuously from two elbow flexor muscles: biceps brachii (BB) and brachioradialis (BR), and the elbow extensor: triceps brachii (TB).
Analysis: Mean, median and peak power and the corresponding frequencies of the three muscles at the beginning, middle and end of the SC. Data compared between groups, among the stages and muscles using ANOVA. Statistical significance was designated at P < 0.05.
Results: The CRF patients feel exhaustion and fail the motor task earlier. EMG power frequencies decrease less in CRF vs. healthy controls from the minimal to more severe fatigue stages. The power frequencies, especially mean power frequency at the minimal fatigue stage in CRF, resemble frequency values at severe fatigue in healthy controls. Thus, further fatiguing the muscle may be difficult. Early task failure may be primarily from an inadequate central drive to fully activate the muscle.
Conclusions: CRF EMG frequency was lower at the beginning of a task. Muscle fatigue was less in CRF during SC. CRF has greater central and less peripheral fatigue than normal individuals.

PE 2.S62

Medical ozone oil suspension applications heal osteonecrosis of the jaws (ONJs) in patients treated with bisfosfonates (BPs). Preliminary results of a single institution protocol

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ONJ is an uncommon condition mainly reported in oncological patients receiving BPs. We previously demonstrated that routinely application of preventive measures before, and during BP therapy, lead to a reduction of 75% in the incidence of ONJ (Ripamonti et al., Ann Oncol, 2008). However, a therapy is still needed in order to treat patients who develop ONJ. Recently, we investigated the effect of the localized application of a medical ozone oil suspension (O3 oil) on ONJ lesions. Ten cancer patients with active ONJ with lesions < 2,5 cm, in good clinical condition were treated with antibiotic therapy 10 days prior the initiation of the treatment consisting in 10 applications of O3 oil on ONJ lesions, at 3 days interval. Herein we report the results obtained in the first 10 patients enrolled with a follow up of at least 4 months, while the second stage of the trial, according to the Simon two-stage design, is currently ongoing to better estimate the response rate.
Patients with breast cancer (n=7), prostate cancer (n=1), NHL (n=1) and multiple myeloma (n=1) had previously received N-BPs treatment in the absence of odontoiatric preventive measures. The mean time between the diagnosis of ONJ and the first O3 oil application was 360 days. All the patients treated showed complete responses, in terms of radiological lesion disappearance with complete reconstitution of oral tissue, which was achieved with 3 applications in 3 patients, 4 applications in 4 patients and 10 applications in 3 patients (the mean recovery time was 26 days). 8/10 patients developed spontaneous sequestrum with expulsion of the necrotic bone.
According to these results few application of medical ozone oil suspension can rapidly led to complete ONJ resolution. Further cases are required to confirm these data, which seem to indicate that ONJ is not only a preventable but also a manageable and curable condition.

PE 2.S63

Improvement of Quality of Life (QoL) of patients with advanced haematological or oncological diseases at a palliative unit

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Aims: A fundamental challenge of the palliative medicine is to improve quality of life. In this study we show the efficiency of a palliative care unit and which patients profit better.
Methods: From August 07 until July 08 Quality of life was assessed in all patients, who were treated at our palliative care unit at the day of admission and the day of dismission. Therefore we used the EORTC QLQ C15 PAL questionnaire. From this patients 24% had an Gastro/Intestinal Cancer, 20% a haematological disease, 22% a gynaecological cancer, 8% a ear-nose-throat cancer 11% an urological cancer, 2% a pancreatic cancer, 4% a lung cancer, 5% a kidney cancer, 3% other cancer and 1% a non malign disease. From this 252 patients 30% died at the station and 70 % could be discharged.
Results: The main reason for admission was pain, Nausea and Fatique. Median duration of treatment was 9 days. The symptom scales for fatique, nausea and vomiting, insomnia and constipation showed a significant improvement between admission and

discharge whereas there was only a minimal improvement in appetite loss and dyspnoea. The physical scales showed stable points, whereas the emotional scales also showed a significant improvement. Furthermore there also was a significant improvement in the overall QoL for all patients. The overall QoL in patients, who had a lower score at the time of admission increased significantly, while there was only a minimal increase in patients who had a higher score.
Conclusion: Treatment at a palliative care unit improves QoL in a relativ short period of time and it allows to discharge the patients into the outpatient setting in a high level of percentage. Although they suffer from an advanced disease, we could reach stable physical functions and could improve the symptomatical and emotional functions during hospitalisation. Furthermore we could show that patients, with a lower quality of life at admission can profit better from hospitalisation than patients with a higher one.

PE 2.S64

The cleo90 subcutaneous needle system for patients on a palliative care unit

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Aim: In palliative medicine the subcutaneous infusion of drugs is an established way of application. Normally, butterfly needles are used for this process. Since the use of it may have some pitfalls, we prospectively investigated the cleo90 subcutaneous needle system which previously has been used for subcutaneous infusion of insulin.
Materials and methods: We prospectively investigated the use of the cleo90 subcutaneous needle system at our palliative care unit for patients with malignant and non-malignant diseases. Patients should be eligible to receive subcutaneous infusions.
Results: We have included 45 patients so far. The mean age was 70 ± 12 years and the relation m : f = 21 : 24. Needles could be used for a mean time of 5 ± 2 days (time span 2-12 days). The process of needle application has been without complications. None of our patients had severe side effects. The use of medications or combinations of drugs in a syringe driver or pump system has been possible. The only problems we observed have been with free running infusions (e.g. NaCl). There sometimes a local induration of the skin has been observed, which has been reversible after removing of the needle.
Conclusion:
1. The use of the cleo90 subcutaneous needle system is easy and safe.
2. The application of drugs alone or in combination is possible.
3. The needle system can be used for a longer time than the previously described one day.
4. Free running infusions must be used with some caution ovthe this system.

PE 2.S65

Disorders in hemostatic system can be target for antitumor treatment of metastatic renal cell carcinoma (RCC)

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Background: In our translation study we suggested that abnormal coagulation could be a negative predictor for response to medical treatment and survival among patients with metastatic RCC.
Patients and methods: 289 previously untreated metastatic RCC patients were evaluated for identification of disorders in coagulation system. Data were compared with group of T1 stage patients without metastasis. 56 metastatic RCC patients with or without abnormal coagulation were randomized to receive low-dose immunotherapy. Baseline characteristics were well balanced. Clinical response was assessed by RECIST.
Results: Abnormal coagulation was present at treatment start in 40% of patients. Serious disorders were revealed in 68% of patients. Rate of hypercoagulation was significantly higher in group with advanced disease (median of fibrinogen 6.2 vs. 3.4 mg/dl for metastatic and early stage renal cell carcinoma; P=.017). Abnormal coagulation was strongly associated with a number of metastatic sites (2 and more metastatic sites vs. 0-1 (P=.001). Patients with high extent of hypercoagulation had significantly higher number of metastatic sites (P=.02). Levels of hypercoagulation do not correlate with prognosis according to MSKCC criteria.
In Kaplan-Maier analysis, patients with hypercoagulation had a significantly shorter overall cancer-specific survival than patients with normal coagulation. Median survival was 8.2 months and 14.6 months, respectively (P=.0011; HR=0.5). Disease control rate (overall response + stable disease) was significantly higher in patients with normal coagulation: 71.4 versus 42.9% (P=.003).
Conclusions: Hypercoagulation disorders were found to be prognostic factor for response rate to systemic therapy and survival in patients with metstatic RCC.

PE 2.S66

Calcium channels blokers as adjuvant of opioid analgesia

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Opioid receptor system is traditionally receiving major attention because of its involvement in acute pain signals perception and transmission. Opioid system is involved in concerted interaction with other systems including ion channels. In chronic pain and/or its medical treatments these systems are non equally activated that resulted in neuroplastic adaptation and destabilization of neurohomeostasis. Very likely, discrepancy between activities of neurohormonal receptor and calcium channels is the reason of tolerance development to analgesics. Possible solution of this problem could be a coapplication of opioid analgesics with calcium channels blockers. We present the synergy between morphine and flunarizine in animal model of acute thermal pain.
Experimental data: Morphine and/or flunarizine or saline (control group) have been injected intraperitoneally to mouse. Hot water (55°C) tail flick has been used as nociception evaluating test. Nociception has been measured at 5, 15, 30, 60 and 120 min post injection.
Results: Morphine at dose - 2 mg/kg reduced nociception (app. 30% MPE - maximal possible effect) Flunarizine in doses up to 20 mg/kg was not significantly active as antinociceptor. Combinations of morphine (2 mg) and flunarizine (10 mg) provided significant synergic potentiation of antinociception. All effects were reversed by naltrexone.
Conclusions: Calcium antagonists itself are weak analgesics. However in combination with opioids provided significant synergic potentiation of opioid analgesia. Coapplication of opioids with calcium channels blockers may reduce requirements for opioid analgesics and in consequence reduce development of tolerance and side effects.
Acknowledgement: Project is financially supported by EU grant "Normolife" (LSHC-CT-2006-037733).

PE 2.S67

Pharmacokinetics of gentamicin subcutaneous administration, an N of 1

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Introduction: Expanding the subcutaneous route (SC) to allow SC administration of antibiotics is a novel idea that would allow further options to treat infections in the hospice setting.
Method: A single healthy male volunteer received a 1mg/kg SC infusion of gentamicin 76mg in 50ml D5W via an abdominal SC needle site, over approx. 25 min. Serum gentamicin levels were obtained on the following schedule: at the end of infusion, hourly X 4, then q 2 h X 6, and finally q 4h X4.
Results: The infusion was tolerated well with only mild discomfort and no tissue injury. Pharmacokinetic analysis of the serum levels revealed: time to peak (tpeak): 0.8 h, concentration at peak (Cpeak): 2.1 mg/L, elimination rate constant (ke): 0.173 h-1, half life (t1/2): 4.0 h, area under the curve (AUC): 15.04 mg/L*h, clearance (Cl): 5.05L/h, volume of distribution (Vd): 29 L (0.38 L/kg).
Conclusion: Time to peak level was similar to findings previously reported for IM administration. Compared to reported findings for IV administration the half life of our profile is longer, 4 h vs 2 h seen with IV use. Volume of administration SC was greater than that reported for IV use. These data suggest that the pharmacokinetics of gentamicn SC may be comparable to IM but less advantageous than IV administration. Further studies are required to comfirm these results.
No outside funding was received for this study.

PE 2.S69

A comparison of bereavement services provided in hospice and palliative care settings in Australia, the UK and the US

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Background: Bereavement support services are recognised as an important part of hospices and palliative care services. Exploratory surveys on the nature of such services have been conducted in recent years in several countries, including the United States, United Kingdom and Australia.
Aim: The aim of this research was to compare and contrast bereavement supports offered by hospice and palliative care services across 3 countries.
Method: From the published results of national surveys of bereavement services in hospice and palliative care settings previously conducted in the US, UK, and Australia, data were analysed for commonalities and differences. The reported descriptive statistics were compared and the survey authors verified that the data were accurate. Additional information was sought where necessary and agreement was reached regarding the main findings.
Results: Through this comparison a number of common aspects of service delivery were highlighted. Common difficulties were also found, including the numbers of nurses delivering bereavement care, the low numbers of paid staff, variations in specialist training, insufficient levels of funding, and the lack of the use of validated bereavement assessment tools.
Conclusions: Bereavement support is an important aspect of hospice and palliative care service delivery. In offering preliminary suggestions on how to improve this component of care, in all three countries further research and policy development is required to address the common difficulties.

PE 2.S70

Living with loss in a social world: A curiosity about what people find useful (and ´un-useful´) in managing their loss

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Aim: Assumptions about how one 'should' feel or behave when facing loss affects those supporting the bereaved and the bereaved. This research aimed to explore what bereaved people experience as useful and 'un-useful' responses towards them whilst managing grief and to increase understanding of how practitioners and society might usefully support people facing the loss of someone close to them. It was hoped to encourage practitioners to appreciate the advantages of adopting a systemic approach within a palliative care setting. The theoretical background is Social Constructionism and Coordinated management of Meaning (CMM)- this challenges traditional 'stage' theories of grieving based upon assumptions of 'letting go' of the deceased person to be necessarily helpful.
Methods: In-depth interviews were carried out with 2 participants, bereaved through the death of someone dying of a terminal illness. The 'CMM Revised Analytical Model' (Cronen, 2004) was used as a method of analysis to explore how participants attributed meanings to coordinated interactions between themselves and others.
Results: Participants were found to be positioned within unspoken rules (or 'social constructs'), commonly associated with bereavement and built upon multiple hierarchies of contexts (e.g. cultural, family beliefs, normative theories of grief) embedded within moral obligations. Interactions were illustrated to have a reflexive effect and what constituted as useful or 'un-useful' in managing loss was influenced by multiple levels of embedded contexts and meaning was dependent on the context in which it occurred. The results supported the notion that there is no one correct way to think or respond to people facing loss but rather, beliefs and ideas that might be more or less helpful.
Conclusion: Social constructions of both the bereaved

person and others have associated consequences for meaning, relationships and actions and these influence the way in which loss was managed.

PE 2.S71

Settling with troubling memories: Exploring the need and possibilities for assisting bereaved families with 'difficult' relationships after death

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Aim: In our support to bereaved people, we find that their relational contexts are often characterised by harmful, abusive or destructive relationships. However, literature pertaining to grief support is largely based upon assisting people in relationships that were predominantly loving and warm, resulting in the marginalisation of difficult and/or abusive relationships, and possibly the lack of appropriate support and care.
Method: A random sample of bereaved families will be drawn who will be interviewed according to a structured questionnaire. The questions will include their perceived experiences of their relationship based on a rating scale. Questions will also include obtaining information on how bereavement support might be more appropriate to their particular situation.
Relevance: Expand and develop appropriate support structures to bereaved families that had experienced 'difficult' and/or abusive relationships, after death.
Conclusion: The findings of these results will be indicated and a justification put forward as to whether these relational contexts require more attention and focus. Based on narrative practices ideas, some of the commonly asked questions will be addressed: These include:
- What if the person who died was physically, sexually, or emotionally abusive?
- How do re-membering practices apply to situations where the death was suicide or murder?
- What if the overriding experience after death is relief? Is this all right and how do we assist people?

PE 2.S72

You've forgotten us! How to balance the competing demands of paediatric palliative care and bereavement support needs. Life Force team share their experiences of running two memory days

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Life Force is a community based paediatric palliative care team established in central London in 2003. The multidisciplinary team comprises a specialist nurse, a community children's nurse, a play specialist/youth worker, respite nursery nurses, psychologist and paediatric palliative consultant. There is no designated bereavement worker. Our aim is to provide a gold standard palliative care service for children, in their preferred place of care, which starts at diagnosis and continues through the bereavement process.
Fourty four children have been supported by Life Force during end of life care. Some of these families we have known for a number of weeks, some for several months, even years. Alongside this, Life Force continues to provide ongoing care for 30 children with a life-limiting diagnosis and complex care needs.
One of the biggest challenges facing Life Force is to balance the competing demands of the active caseload whilst ensuring adequate bereavement support to the families.
Through this presentation we will describe how a successful bereavement program has been established. This includes a sibling support program, starting prior to the death and continuing for six months to a year after the death.We will also describe how a memory day has been developed, outlining the philosophy and aims for the day. Part of the presentation will explain the organisation and planning needed for a memory day, the role of volunteers and parents and how parental feedback has helped structure future events.

PE 2.S73

What to tell children and not to tell, if their parents are dying with terminally ill disease

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Children are growing human beings and needs to understand/informed what is going around them. A child understanding of death is influenced by age related developmental stages Capital Health [2006].
Purpose; to explore if it is wise to let the children know that their parents are terminally ill/dying.
Children often perceive that something is wrong even if they are not told, because routines are disrupted and people close to them may look and act differently.
Working at a palliative care/ Hospice set up, it has come up strongly that it is better to explore with the children of what they understand of the sickness and death first, since our culture forbid adults to discuss death with children especially if it involves parents. Survey done at the hospice, shows that three [3] out of five [5] children cope well with the information being paced well and relating the situation to the previous one especially of illness/death such as loss of a grandparent.
Children who are supported, cared for and loved, with extra kisses, hugs and time spent together cope well with bad information than those left without information. Two [2] out of five [5] don't cope due to lack of proper support and the way information are given and this affect them in later life. Allowing children to express their feeling and answering questions simply and honestly has shown improvement in coping with illness/ death. Half of patients cared for by the hospice team shown that their children were being left out of the correct information. Children need a lot of support and understanding especially when bereaved by parent and know they are cared for, understood and can contribute in any way.
Conclusion: We need to change our African culture and start involving our children in decision-making and let them understand what is going on and there is need for further researches on parent's illness and death.

PE 2.S74

Life with your children after the death of your partner

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The Specialist Palliative Care service in Cork caters for approximately 35 patients each year who are parents of young children. Research evidence suggests that the single biggest predictor of good outcome for bereaved children is the coping of the surviving parent.1 As a result, the bereavement team endeavours to support surviving spouse by facilitating a support group for surviving parents each year. The group is run by a senior social worker and a volunteer who has been widowed with young children and who attended a support group after the death of their spouse. The group meets on a monthly basis to offer bereaved parents an opportunity to meet with others in similar circumstances. Group members can exchange information and ideas about coping with their loss and with helping their children to grieve. This is the eighth year in which a group is being held.
Much of the available literature in pamphlet form which addresses loss either deals with loss from an adult's or from a child's perspective. There is a lack of appropriate material which directly addresses the issue for parents of dealing with their own and with their children's grief. Four former members of the surviving parents programme volunteered to produce a leaflet for newly bereaved spouses drawing from their own experience of loss. This leaflet aims to highlight issues that may arise for parents in the first weeks and months after a loss and offers some useful suggestions. It also aims to reassure newly bereaved spouses that others have had their experience and that they will learn to cope with their situation. The project is a unique and valuable collaboration between a hospice based social work team and volunteers who support the bereavement programme.

PE 2.S75

Sharing the journey: Role modeling as a teaching strategy in palliative care

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The aim of this qualitative research study was to describe the role modeling behaviours of exemplary palliative care nurses and the effect on student and novice nurses.
The research paradigm is phenomenology. The participants were palliative care nurses identified by their colleagues as outstanding role models. A purposive sample of 8 nurses participated. Data were collected by interviewing and observing participants over a period of 40 weeks for 8 hours per week. Two hour interviews with each nurse were recorded and transcribed. Field notes were used to record observations. Data were analyzed systematically for themes by attending to three points of reference: recurrence of ideas within the data, repetition, and forcefulness with which an idea was presented. The study abided by the Tri-Council Policy Statement on the Ethical Conduct for Research Involving Humans.
The role modeling behaviours discovered included: attending to the little things, making appropriate connections, maintaining a light-hearted attitude, and affirming others. The major effects of role modeling on student and novice nurses was affirmation of their value and learning the tacit. The exemplary nurse role models were also impacted by the experience as it helped them to find meaning in their work by sharing the journey.
In conclusion, this study has practical implications for those who educate palliative care professionals. Role modelling is a strategy for teaching many of the difficult to teach skills and attitudes necessary to becoming an exceptional palliative caregiver. For example, how is it possible to teach someone that using silence is a powerful skill in caring for a dying person other than by role modeling? How can one teach a novice how to make an appropriate therapeutic connection with a family member other than through role modeling? This study revealed the importance of cultivating role models as educators in palliative care both for the learners and for the caregivers.

PE 2.S76

Survey of palliative care concepts among medical students and interns in Austria: A comparison of the old and the new curriculum of the Medical University of Vienna

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Background: To improve the level of awareness in palliative care concepts, the new curriculum at the University of Vienna includes sixteen hours of palliative care education. The old curriculum did not include palliative care education.
Aim: To compare the level of awareness in palliative care concepts among 4th year students of the new curriculum of the University of Vienna with interns who finished their studies in the old curriculum.
Material and methods: 440 medical students in their 4th year and 149 interns participated in a survey study. Data were collected after the survey and the responses were analyzed.
Results: Data analysis consists of completed survey obtained from 83% and 67% of the students and interns. We observed that students reported higher theoretical knowledge of palliative care concepts as compared to interns, whereas interns were better in performing practical aspects of palliative care. A significant percentage of students and interns would like to learn more about palliative care in their curriculum, although this was more present among interns (72.7% students and 92.6% interns, $p<0.0001$, respectively).
Conclusion: Although palliative care education is already included in a compulsory manner in the new curriculum of the University of Vienna, almost two

third of all students would support more implementation of palliative care issues throughout the curriculum. To further improve attitudes and skills towards patients at end of life, palliative care education should be augmented in the new curriculum.

PE 2.S77

The landscape of formal CME in palliative care for GP´s in Flanders, Belgium

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Aim: Most of the palliative patients in Flanders want to be taken care of at home by their general practicioner (GP) until the moment they die. What possibilities are available for the GP to keep up the level of his palliative competencies to address this task? We want to describe a complete view of the offer of continuing medical education (CME) in palliative care. We describe the content, the format, the organizing institutes and the educational techniques. We want to know if the target population of GP´s is reached in a sufficient way and if the impact of the educational moment is evaluated.
Methods: A questionnaire (based on literature and expert review) is send by e-mail to all institutes in Flanders who organize CME for GP's (local networks for palliative care, circles of GP's, hospitals and major GP organizations and palliative care organizations).
Results: The questionnaire has been sent in october 2008 and the results are expected in november 2008. After statistical analysis, the results will be compared to the literature.
Conclusions: Suggestions will be made to adapt the CME landscape following EAPC curriculum suggestions.

PE 2.S78

A descriptive survey to assess the palliative care knowledge of generalist public health nurses in the mid west region of Ireland

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As the focus of care of the dying has shifted from hospital to home, the quality of terminal care in the home and the possibility of a home death depend to a great extent on the care provided by generic community health professionals. The significance of improving the skills and supporting the primary care team in order to facilitate patient preferences to die at home is clear.
This study aimed to examine the palliative care knowledge base of generic community nurses (Public Health Nurses) in one region (the mid west) in the Republic of Ireland. The information gained from this descriptive research could then be used to plan future educational programmes for these nurses. Upon ethical approval, the existing questionnaire (Ross et al, 1996) was adapted, validated and piloted for use in the Irish setting. It was administered by post to the population of PHNs in the area, and achieved a fifty-five per cent response rate.
Results indicate that the sample have a fair level of knowledge of palliative care, slightly lower than in other countries. The mean score on the questionnaire was 12.6 out of 20. Akin to previous research worldwide, this study reveals respondents' deficits in knowledge are in relation to pain and symptom control. Participants demonstrated a good knowledge of philosophical, psychosocial and spiritual issues. Recommendations from this research include more specific assessment and planning of education for this group of nurses by the Specialist Palliative Care Service. The tool could serve as an important assessment tool for not only for a variety of nurses in Ireland but could be further validated for use with other professionals.
References: ROSS, M.M., MC DONALD, B., MC GUINNESS, J. (1996) The palliative care quiz for nursing (PCQN): the development of an instrument to measure nurses' knowledge of palliative care. Journal of Advanced Nursing. 23, pp.126-137.

PE 2.S79

Exploratory study of primary health care providers´ feelings of comfort with caring for the terminally Ill patients using multiple regression and structural equation modeling

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Aims: The main purpose of the study was to explore the variables influencing the feeling of comfort with caring for the terminally ill patients (TIPs) of a group of primary health care providers who completed a palliative care course in Western Canada. Secondary objectives were to establish the psychometric properties (i.e.: reliability and validity) of the measuring instruments used to assess their changes in knowledge and self perceived comfort levels with PC competencies; to assess the impact this course had on their knowledge, and self-perceived comfort levels with PC; and to investigate the fit of a hypothesized model of primary healthcare providers' feelings of comfort with providing palliative care
Methods: Data consisted of scores on pre and post knowledge quizzes and comfort level surveys from 300 learners who completed the LEAP course in 2005 and 2006. Statistical analysis involved descriptive statistics and reliability analysis of the measuring instruments; repeated measures tests were used to compare pre vs. post course results; exploratory factor analysis was conducted to investigate the factors involved in the feeling of comfort with caring for the TIPs experienced by primary health care practitioners, and aided in the process of establishing construct validity of the instrument; multiple regression analysis was conducted to investigate the proportion of variability in the dependent variable (post-course comfort level with caring for the TIPs) explained by the dependent variables chosen for the model (pre-course knowledge; post-course knowledge; discipline; perceived change in comfort levels due to the course; and pre-comfort levels with caring for the TIPs); the result of this analysis was used to construct a theoretical model to explain variance in the feeling of comfort with caring for the TIPs. Structural equation modeling was used to test the proposed model.
Results: Study results will be presented during the conference.

PE 2.S80

What do medical students learn about palliative care?

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Aim: All doctors should be able to provide basis palliative care. This implies that education in palliative care should be teached in the undergraduate medical curriculum. It is unclear whether medical schools in Europe have a structured programme for such education, whether this is mandatory or facultative and what aspects are covered. Therefore, as part of a EU-funded study 'Best practices in palliative care in Europe', we wanted to answer the question:
What is the status quo of undergraduate palliative care education in seven European countries (England, Poland, Germany, Spain, Netherlands, Belgium, France)?
Method:
Design: Structured survey.
Population: Persons whom the deans considered most capable to answer question about undergraduate education in palliative care.
Setting: All medical faculties in seven European countries.
Procedure: Based on a literature search and expert interviews with persons from different European countries as well as the European taskforce of education, we developed a structured questionnaire with multiple choice questions, meant to get an overview of facultative and mandatory education in all kind of aspects of palliative care.
In September- October 2008 we asked the deans of all medical faculties of seven European countries- Poland, Germany, Netherlands, Spain, England, Belgium and France- to give the name of the persons who can answer this questionnaire. In October we sent the questionnaire to these persons.
Results: Spring 2009 we will be able to deliver a picture of undergraduate palliative care education in these seven countries. All results will be available and presented during the EAPC conference in Vienna.
Conclusion: Will be available in spring 2009.
Keywords: Medical, undergraduate, education, curriculum, student, teaching, learning, training, assessment, medical schools, palliative, palliation, terminal care, end of life care.

PE 2.S81

Education and training for physiotherapists in palliative care. Experiences with the curriculum "Physiotherapy in Palliative Care"

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In 2007 the physiotherapists (PTs) P. Nieland, S. Mehne (Germany) and R. Simader (Austria) developed in cooperation with the German Association for Palliative Care (PC) the curriculum "Physiotherapy in PC".
Since 2008 this curriculum is basis of a 40 lesson education for graduated PTs in Germany and Austria. These one week trainings are given by experienced members of all important professional groups in PC such as physicians, PTs, psychologists, councillors, social workers, pastors, philosophers and volunteer PC staff.
The main objectives of these courses are to improve knowledge in diagnosis and medical treatment strategies, communication skills and bio-psychological background, to deal with ethical and spiritual aspects in PC and of course to improve planning the physiotherapy process on terminally ill patients on evidence based level.
Since 2008 seven trainings were held and about 120 PTs participated in this program. Furthermore 6 courses are planned for the year 2009. It is obvious that there is a big PTs´ need to be trained in PC because PC is still rarely taught in under- or postgraduate PT education. But also in this belonging the curriculum made PT education facilities more open minded on this topic. All courses were evaluated and currently we discuss the 1st year and possible adjustments. The results are presented at this congress.
Beside of the obvious result of the courses for PTs - being the improved abilities to work with PC patients and in PC teams - we see vast improvements in the communication and exchange of knowledge between the different professional groups. So improvements are on both sides: PT and PC System.
The Curriculum was already topic at the Europ. Congress on PT Education in Stockholm and the ANTEA Worldwide PC Conference in Rome and there had been requests of other countries to get more information and even translated editions. We are sure that the curriculum has been a positive step for both PTs and the PC System.

PE 2.S82

Japan Partners Against Pain® (JPAP®) activities and effects on pain management awareness in the medical community

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Aims: The misperception that narcotics for medical use should be prescribed only for patients with end-stage cancer is common among many medical professionals and patients in Japan. Patients and even physicians have strong concerns about the medical use of opioids because of addiction or other problems associated with these drugs. Pain treatment in Japan lags behind the West because of a lack of knowledge and/or experience

in pain treatment among medical professionals and patients. While the Japanese government has just begun taking aggressive measures to improve cancer treatment including enacting the Cancer Control Act in 2007, it is still a struggle to deliver proper treatment due to a lack of knowledge and education on pain management.
To address these issues, medical professionals specializing in pain treatment established Japan Partners Against Pain® (JPAP®) in 2003.
Methods: JPAP® is a nonprofit organization devoted to spreading awareness of pain management and appropriate pain medication based on our belief that "pain should not be tolerated."
Results: As of August 2008, the number of JPAP® medical professional members has surpassed 2,300, almost half of whom are doctors.
Major activities of JPAP® include the distribution of accurate information on pain management to medical professionals and the general public. These include lecture meetings, case conferences, dispatch of instructors, and events for media & the general public.
In 2008, JPAP® produced a short documentary featuring two JPAP® physicians proactively engaged in palliative care to shed light on the issues shared with those involved with palliative care.
Conclusion: JPAP® has been influential in spreading the message of appropriate pain management to a wide range of medical professionals and the general public. We hope to continue our efforts to raise the level of care and ensure that no Japanese cancer patient has to suffer from pain.
JPAP® is funded by a grant from Mundipharma K.K.

PE 2.S83

A project of transfering expertise from a hospice in a hospital setting to local nursing homes - Experiences

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Aim: To transfer expertise in palliative care from Hospice Lovisenberg to local nursing homes. Hospice Lovisenberg is a specialized palliative unit at the medical department in a diaconal hospital in Oslo, Norway.
Methods: Two experienced palliative nurses and one palliative doctor part time were employed in the project. The project period was two years. The funding was from the health authorities.
Three local nursing homes were chosen in three different town districts in Oslo. In each nursing home one short-term ward was selected to participat.
All employees in these wards filled out a questioner about their own view of their own competence in different palliative fields.
The project nurses made all day visits to the short-term wards to get to know the staff and learn about how the nursing homes managed their patient. For us it was important to also focus on what the Hospice could learn from the nursing homes.
Each nursing home ward sent nurses and helping nurses to the Hospice for one weak each. The expenses for this were paid for by the project. All nursing homes had several different teaching courses in palliative care.
The project nurses visited the nursing home regularly each week and offered assistance and guidance. The nursing homes could also contact the nurses whenever needed by phone.
Local resource groups were created in each nursing home and the project nurses continued to follow up the nursing homes and the local resource groups at regular intervals and whenever needed throughout the project period.
Results: In evaluating the project it was viewed as a success for all participating institutions, both by the leaders and by the staff.
Conclusion: The main criteria for the success were that the expenses was paid for by the project, making the staff in the nursing homes feel ownership to the project, the regularly guidance done by the project nurses and devoted leaders.

PE 2.S84

Teaching professionals on how to support patients and families with cancer

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There is sound evidence to support the notion that the provision of psychosocial care improves the outcomes of patients with cancer. Implementation of this care is focused on that health professionals have the necessary communication skills and understanding of the emotional state of the patients and their families.
In order to address these issues, a number of workshops were implemented targeting specific groups of professionals. The professionals included doctors from the pathology and surgical wards of a public hospital, nurses from all the departments of two public hospitals and social workers from the government social welfare office. The workshops included:
(a) the use of video with professional actors,
(b) verbatim scenarios from cancer patients,
(c) role playing scenarios in order to reconstruct the dialog between the health professional/patient/family.
Since for many professionals this was their first time exposed to the subject, the framework of the workshops concentrated on the most common and basic communication needed by the professionals for effective communication. These included four areas:
(a) Barriers in communication between health professionals and patients with cancer,
(b) I do not know what to say, handling difficult questions with cancer patients,
(c) Anger management in cancer,
(d) Breaking bad news.
The results of how each professional group responded to the training are discussed extensively. However common findings for all groups are that health professionals were exposed to little or no training in their professional training and that the workshops have helped them to deal with situations that have being avoiding so far from feelings of inadequacy.
The findings from the training indicate an urgent need to develop a more permanent framework for providing health professionals with both skill development and ongoing support in order to integrate psychosocial aspects of care and optimize patient care.

PE 2.S85

An educative journey leading to better support for adults with intellectual disability who have developed an advanced or progressive, life-limiting illness

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There is wide recognition that people with intellectual disability (ID) may miss out on helpful palliative care services in the face of advanced or progressive life-limiting illness. Our care of a person with ID highlighted our gap in knowledge of ID and the additional difficulties arising for patient, for family and for carers-including our own staff. We set out to explore local ID support networks and meet key workers in the field to improve our understanding and work together towards a supportive pathway to care, using the UK Help the Hospices 'Widening Access' model.
Initial meetings identified a huge gap in our understanding of support services and supportive material for people with ID, but also a huge gap in their understanding of health, social and specialist palliative care services available to support through difficult times.
Working together has led to revision of our 'referral in for palliative care services' form, creation of a 'fast track' pathway towards early face to face contact with the client and their key worker, real engagement with that key worker, and with key family, and increased confidence for us all in managing advanced illness together. We now use literature introducing palliative care to adults with ID. We now understand patient held records widely used in support of people with ID, but largely unrecognised outside of that field, with their useful health summary and information on an individual's understanding and ways of expressing.
There is firm recognition now that most adults with ID prefer to stay at home when dying. Extra hands on care at this time is now on the Commissioning agenda. We have developed and run a day conference on 'Intellectual Disability: ensuring excellence and empowerment in end of life care', to which individuals with ID, and people bereaved of a loved one with ID contributed. The work, and conference have really improved local supportive relationships and identified service development needs.

PE 2.S86

Government and NGOs cooperation to improve of palliative care specialists' education and training in Ukraine

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Aim: The problem of education and training of medical students, doctors, nurses, volunteers, patients´ family members for Ukrainian Palliative Care (PC) Service is crucial. The first Hospices and PC Departments in hospitals were founded in 1997 - 1998. However, there is not developed a system of PC specialists training untill. This is one of the reasons of insufficient access of patients to PC. The objectives of our surveillance were to study the situation concerning of PC specialists' training and develop propositions for Ministry of Health (MOH) and Ministry of Social Policy and Labor of Ukraine (MSPLU) to improve it.
Methods: Different methods we used: interviewing with regional Health Care Authorities using a questionnaire approved by MOH; and site-visiting of selected Regions using interviewing of doctors, nurses, social workers, patients, NGO representatives etc (345 persons). Additionally we analyzed statistic data, evaluated Medical Universities and Colleges Curriculums, made an assessment of estimated needs Ukrainian Public PC Service (UPPCS) in specialists according of the International approaches.
Results: 85% of regional health authorities unsatisfied with the current Public PC legislation; 75% - support the development of PC Facilities. Estimated 245 doctors, 4500 nurses and nurses' assistants for hospices, and 1400 doctors and 5500 nurses for multidisciplinary home PC teams should be trained in Ukraine.
Conclusion: To improve of PC specialists' training UAPC in collaboration with MOH Institute for Palliative and Hospice Medicine, Institute of Gerontology and National Postgraduate Medical Academy developed the PC Training Curriculum for health providers and medical students. About 250 health providers were trained. In 2008 we are developing of the National PC Developing Program till 2014. The important part of the Program is PC specialists, volunteers and patients' family members training with NGOs and Governmental institutions collaboration.

PE 2.S87

Results of dental screening during bisphosphonate therapy

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With increasing of bisphosphonate therapies reports about bisphosphonate induced osteonecrosis of the jaw are growing. Prophylaxis of this complication is important. Since 2005 all patients with bisphosphonate therapy got a clinical and radiological (orthopantomography) dental screening.
We investigated 32 patients (5 male, 27 female), middle age was 69,5 years. All patients got an intravenous bisphosphoante therapy with zoledronat, middle over 16,3 months. Main diagnoses were metastatic breast carcinoma (16), multiple myeloma (9), lung carcinoma (4) and renal cell carcinoma (3).
17 patients (53%) hat no dental foci. 11 patients (34%) had foci; 4 patients (12%) had osteonecroses before therapy. During therapy 2 patients developed osteonecroses; both had foci before.
Conclusion: 34% of asymptomatic patients hat foci with need of dental therapy. It seems that these foce have predictive value for later osteonecroses of the jaw, so that dental surgeons should be integrated in therapy of patients with parenteral bisphosphonates.

PE 2.S88

Learning by doing: Integration of a research project on communication into a master´s degree program

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Aim: In December 2007 Dresden International University (DIU) started a master's degree program for Palliative Care. In the development of the curriculum an attempt was made to integrate acquisition of practical knowledge, perception of published primary research, discussion of research methodology and performing independent research.
Methods: In the field of communication the participating post-graduate students received a problem based task of developing a small conjoint research project based on the interview of a group of patients at their respective institutions. Participants analysed published studies based on interviews and/or questionnaires (among others Hagerty et al. (2005) JCO 23:1278, Kleeberg et al. (2005) SCC 13:303, Schofield et al. (2003) Ann Onc 14: 48), used them and additional input from the group to generate a structured interview on aspects of primary disclosure of diagnosis.
Results: An 19-item (most of them subdivided) questionnaire was generated. Some items interviewed the patient about his own communication experience (patient as "witness"), others asked for preferences and advice for doctors (patient as "expert"). Respective merits of different types of questions were discussed (open, structured, Likert-Type etc.). With the help of tutors a protocol was written and discussed with an IRB. In the practical phase, students interviewed 152 Patients at their respective institutions. In further seminars generation of a study-database and statistical analysis of the data was subject of further teaching. This is also intended as preparation for individual research towards a master thesis of the participants.
Conclusion: Within the context of a master degree program it is possible to integrate a group working at different sites into the conjoint work on a small research project and generate experience on the subject and methodology and meaningful data at the same time.

PE 2.S89

Development of telephone advice training for hospice in-patient nursing staff

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Background: NICE guidance for supportive and palliative care for adults with cancer recommended generalist access to specialist palliative care advice, 24/7.The Marie Curie 'Making the most of our Hospices 'project demonstrated patient and carer need for consistent, accurate advice around the clock. Education needs assessment of 15 senior nurses demonstrated a lack of confidence and training requirement to provide telephone advice.
Aims: The project aimed to develop a training programme for in-patient nursing staff to provide telephone advice.
This would:
• explore the rationale for giving telephone advice
• assess advice given
• explore participants feelings about giving telephone advice.
The benefits of this training would be consistent, accurate and auditable 24 hour telephone advice.
Methods: There was no published evidence on training for the provision of telephone advice. The "Pan-Birmingham advanced communication skills course" and "The Samaritans - volunteer phone training" models were utilised in planning the training.
Results: We developed a one day interactive course including:
• Experiential group work with feedback and discussion
• Telephone Triage role play with individual feedback and evaluation
• Group discussion.
23 Staff Nurses and 1 Ward Manager took part.
It was delivered by the lead communication skills training nurse and a doctor. An iterative, colour coded telephone advice flowchart was developed that provided signposting to locally accepted network guidelines.
Evaluation included questions on the training, nurse fears and confidence levels. Pre-training fears were around role, knowledge, skills and training.
'Not confident' reduced from (9)37% to (1)4%. 'Fairly confident' increased from (12)50% to (15)63%.
'Confident' increased from (3)13% to (8)33%.
Re-assessment continues as the service is used.
Conclusions: Experiential training with guideline support increases staff confidence in taking part in a new telephone advice service.

PE 2.S90

Which competencies do care givers need for providing spiritual care?

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In the Netherlands there are several initiatives aimed at the structural embedding of spiritual care in end of life care. In 2008 a directive Palliative spiritual care was presented and the Expert Network on Existential Issues and Older People was founded. Approximately 20 out of the 74 Networks of Palliative Care, responsible for the development of palliative care, pay explicit attention on the improvement of spiritual care. Both by developing education programs on spiritual care, as well as establishing support teams where patients and care givers can request for a spiritual care professional at home.
Aims: Further development of the education on spiritual care, by education programs as well as structural embedding in the basic training of care providers, is urgent as is agreed by the members of the National Platform Palliative Care; a group of representatives of a large number of important organizations for palliative care in the Netherlands, including the Ministry of Health, Welfare and Sport. For the further development of a coherent offer of education programs on the long term, it is important to agree which competencies both informal and professional care givers need to provide adequate spiritual care.
Methods: In this study it is investigated which competencies in knowledge, skills and attitude are needed, concerning the recognition of spiritual needs, the provision of adequate support, and proper reference and co-operation with spiritual care professionals. For this purpose literature, teachers and key persons on spiritual care, and representatives of the National Platform Palliative Care will be questioned on the competencies they think are important. In expert meetings the minimum set of competencies will be discussed for the different disciplines involved in palliative care.
Results: At the EAPC conference the results of this investigation will be presented.

PE 2.S91

General practice palliative care education initiative: Program review

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Aims: From 2002 Queensland Health has allocated annual funding for the development of palliative care education and skill enhancement for General Practitioners (GPs) throughout Queensland, in three individual funding categories (mentoring & leadership, resource development, and conference or workshop activities). Funds are provided to individual GP Divisions who are responsible for developing and delivering the activity. This review aimed to evaluate the outcomes from the program to date, and provide recommendations for ongoing development of the program.
Methods: The review involved analysis of final reports submitted by email and phone survey of the 18 GP divisions within Queensland. Survey topics included system processes, and self reported outcomes including sustainability of outcomes.
Results: Since 2002, of the 46 applications received, 37 were funded. Total funding awarded for the GP Education Initiative since 2002 is $324,095. 13 (or 72%) of the 18 GP Divisions across Queensland accounted for 34 of the 37 funded applications. Eleven (or 61%) of the 18 GP Divisions have provided comment as part of the evaluation process^. Positive outcomes of the initiative have included the development of eight new resources, 27 clinical placements and 440 GPs have participated in palliative care-related conference activities across Queensland.
Conclusions: Respondents reported the initiative was effective in providing educational activities for GPs across Queensland. Limitations noted included inefficient application and review processes and inadequate funding to achieve sustainable outcomes. Recommendations for improvement include building in options for updating previously created resources, limit funding to mentoring projects (as this duplicated other initiatives currently available to GPs), and refining the application and evaluation processes.
*Divisions are currently being contacted individually by phone in an attempt to improve the response rate.

PE 2.S92

Certified palliative care courses for nurses, course leader qualification and activity in Germany - Analysis of nation-wide data from 1998 - 2008

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Background: In Germany, there are curricula (CU) for further/continuing education in palliative care (PC) for nurses (N), 160 hrs (1996); psycho-social professionals (PSP) 120 hrs (2002) (both leading to laws on qualification requirements in in- and outpatient PC; physicians (160 h, 2004) and physiotherapists (40 hrs 2006). All CU cover aspects of cancer pain therapy, symptom control, communication, ethical and legal matters, dealing with death and dying, bereavement, and others. Since 1998, course leader (CL) training is available. Only courses based on these CU by Kern, Mueller, Aurnhammer are certified by the Deutsche Gesellschaft fuer Palliativmedizin (DGP) and Deutscher Hospiz- und PalliativVerband (DHPV). The Academy for PC in Bonn is the authorised agency for the certification of courses according to these CU, and for documentation and evaluation. This is the first study that analyses the nation-wide development of courses for N and CL activities in the past decade.
Method: Descriptive analysis of national database with SPSS for Windows V. 16.0.
Results: Starting with the first CL course in 1998 with 9 participants (P), until 2003 49 and as of 2008, a total number of 103 CL were certified; 77 (75%) are still active. The number of courses for N increased from 1 (1998) to 35 (2003) and 131 (2008); total no. over the 10-year period 532, with a total number of 9576 P. A check of postcodes of the institutions offering certified courses for N showed uneven distribution across Germany. More detailed results will be presented.
Conclusions: The increasing numbers of courses and P reflects the rapid development of PC in Germany. Against the background that PC is only marginally incorporated in N education, the fact that about 10,000 N were trained in PC shows a high interest of this profession in PC. The number of courses for N should be increased, a more even distribution across Germany is needed. Qualitative research to explore the outcome of PC courses is needed.

PE 2.S93

Nursing education in palliative care - Challenges and opportunities

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In 1997, as a result of the high need for Palliative Care in Romania and great request for education and training in this area at national level, Hospice "Casa Sperantei" - the first Romanian hospice - opened "Princess Diana Study Centre for Palliative Medicine". The achievements of Hospice "Casa Sperantei" are confirmed in the study "Transitions in end of life care" by David Clark and Michael Wright (2003) where the authors recommend: "Brasov could further develop its regional role in the Balkans, supporting Albania, Bosnia-Herzegovina, Bulgaria, Romania, Macedonia, Moldova and Serbia". Many resources - time, people, finances - have been dedicated to our new mission: "to consolidate Palliative Care education, through both practical and theoretical courses, for medical and allied health professionals throughout Romania and Balkan region". The results consist in 163 nurses and doctors educated and trained in Palliative Care from 11 countries: Albania, Bosnia-Herzegovina, Bulgaria, Greece, Macedonia, Moldova, Russia, Serbia, Tajikistan,

Ukraine, Uzbekistan. Up until now we faced many challenges - cultural particularities, limited resources, different educational back rounds - but at the same time we encountered unique opportunities - adapting our knowledge and skills to lack of resources, learning to keep our mind opened to new experiences, develop ourselves as medical professionals. At the moment we provide Nursing Education in Palliative Care in the Region - at different levels: basic education for nurses, continuing medical education, post-graduated courses - depending on the needs and requests. The challenges we face and the opportunities we encounter make the theme of this presentation.

PE 2.S94

Contribution of palliative care toward developing nursing as an autonomous profession in Romania

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Developing a new profile of a profession like nursing has to go through several steps: individuals to become aware of their own role and contribution in the care of patients, models to be established, replication and dissemination of models, joining voices into one professional organization. All this takes place in a given context that can facilitate or hinder the process. For the last 20 years, since the Revolution against communism in December 1989, Romania has changed progressively, including the medical system. The inherited centralized system of organizing health care assumed hierarchically subordination of a profession to another - ex. nurses to doctors. The intended pattern since 2002, when Nursing Universities have been established and the National Order of Registered Nurses has declared their position toward developing nursing as an autonomous profession, is to implement progressively new clinical, educational and managerial responsibilities for nurses. Palliative Care nurses from Hospice "Casa Sperantei", already perceived as an island of autonomous professionals working interdependently with other members of the multidisciplinary team, became aware of the opportunity they have to influence the image of their profession through the power of own example. Being a matter of changing attitudes, prejudice and out of date conceptions it takes patience, time and perseverance. The purpose of this presentation is to analyze the contribution of Palliative Care toward the development of nursing as an autonomous profession in Romania and to bring hope and encouragement to nurses from ex-communist countries that face the same situation. Change is possible and it happens with the help of open minded people.

PE 2.S95

Patient awareness and knowledge of clinical trials: Do research specific educational interventions increase patient enrollment?

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Background: There is ample research that characterizes the barriers to patient participation in clinical trials. Reports cite only 2-4% of cancer patients participate in research. In addition, up to 85% of patients indicated they had no knowledge that clinical research was being undertaken in the facility in which they were being treated, or that they may have been eligible for a study. We hypothesized that a variety of research specific educational interventions could measurably increase enrollment.
Methods: All new patients received an invitation to an orientation session at which patient research was highlighted. Patients were mailed a survey which captured understanding of clinical trials and exposure to research information. In two weeks, an information pamphlet with website address was mailed to the patient. The pamphlet and website offered general information, frequently asked questions, and provided links to additional information. A post test was sent to initial responders at three months.
Results: During the time of testing, patient enrollments decreased. There were several confounders that may have influenced this trend. Over 4 months, 903 Survey 1 were mailed, with a 45% response rate. A response rate of 55% was achieved for Survey 2. There was no statistical significance between entry into a clinical trial and; orientation session attendance, receiving the information package, or viewing the website. Of note, after 3 months of active treatment, 52% of patients indicated that they had not been given information about clinical trials by their physicians or nurses. 87% of patients indicated they were not participating in research at the time of response.
Conclusions: When considering resource allocation, development of quality educational interventions may be beneficial; however, we propose that information relating to research should be delivered from primary health care providers directly to patients.
Funding: Alberta Cancer Board.

PE 2.S96

Undergraduate education in palliative care (PC). First 3 years of experience

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Traditionally medical students have received little education in PC usually without adequate preparation for interdisciplinary team work.
Since 2005 an elective, 80 hours subject, on PC is dictated. Main topics include: definitions, interdisciplinary team work, decision making, communication, treatment of pain and other symptoms, ethics. Teaching is case based in large groups with elective rotations to an acute care hospital PC team.
Since the first year voluntary and anonymous initial and end of course surveys were administered to all the students that choose this subject (total: 308 students).
Aim:
a) of the initial survey: to evaluate the reason of choosing this subject and the grade of knowledge about the objectives of PC,
b) of the final survey: the change in the grade of knowledge about the objectives of PC and the grade in which the course will impact in the future practice of this students as doctors.
Results: Average age: 23 years. Sex: 72.8% females.
Initial survey (278 out of 308. Response rate: 90%, considered excellent):
70.9% chose the subject for interest, 23.9% for curiosity and 4.3% for obligation.
92.7% could identify objectives of PC regarding patient care correctly, but only 56.7% identified objectives regarding family members care.
Final survey (224 out of 282. Response rate: 79%, considered very good).
95% could identify objectives of PC regarding patient care correctly and 83.5% could now identify the objectives regarding family members care ($p = <0.00001$).
For 87.1% students this course will positively impact in their future practice, for 89.3% the contents were useful and for 83% the course positively changed their vision of interdisciplinary teamwork.
Of the 190 students (61.6%) that carried out the rotations (77.1% qualified them as very good or good (37.2% and 39.91% respectively).
Conclusions: Although basic concepts of PC were already known, this course helped to complete and better integrate previous knowledge.

PE 2.S97

Palliative education for volunteers: Towards harmonization of competencies

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Context: Until 2007 about 180 volunteers representing 7 different institutions used to work with severely ill and dying patients in healthcare and living settings (elderly homes, academic and regional hospitals, home, institutions for mentally disabled people). These volunteers had followed disparate trainings with various durations, some even had no training at all.
Goal: To create a unique palliative care training program for volunteers included in the context of Palliative Care Vaud (PCV), elaborated, structured and set up by Health Care Vaud (HCV).
Objective step 1: To identify the required competencies for volunteering in the palliative care field through the DACUM method (Developing A CurriculUM).
Tool: 2 days' meeting/12 volunteers from 4 different institutions+2 moderators+2 observators+1 manager HCV.
Results: Elaboration of a catalogue including 8 domains of competencies subdivised in 122 tasks.
Objective step 2: To design a palliative care training program based on identified competencies (domains and tasks).
Tool: 5 persons working group representing the actual courses and HCV.
Results: To build and set up a palliative care training program on both pedagogical (contents of the basic and continuous training, teaching and learning methods, etc.) and administrative (duration, frequency, application, link with specialized palliative care settings, etc) levels.
Conclusion: The future palliative care training program for volunteers has been designed on the base of the clinical practice of the volunteers themselves, which guarantees a true coherent education concept linked to reality. Volunteers are essential partners within PCV. It is therefore crucial that they benefit from a basic common training, independantly from the setting where they practice and the age of the patients they accompany. The training will allow them to acquire knowledge and competencies in the palliative care domain and specifically in the field of interdisciplinary teamwork.

PE 2.S98

A quality frame for nurse education in palliative care in the Netherlands

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Aim: A committee of the Dutch Nurses Association for Palliatieve Nursing (V&VN PV) has developed a quality frame in which competences for different levels of palliative care nursing are described. Reason for this was a big need for such criteria, e.g. in educational institutions. Its purpose is to evaluate and audit existing nursing educational programs (curricula) and to offer a description of competences on different levels when new educational programs and extra training are developed.
Methods: The committee developed the quality frame based on three documents; "A guide to the Development of Nurse Education in Europe " (EAPC 2004), the Professional Profile of Nurses working in Palliative Care (V&VN PV) and the Professional Nursing Educational Act (VBOC 2004).
Results: Following the European Guideline, three course levels are differentiated; basic (A), advanced (B), and specialized (C). In the quality frame the committee has added an extra level (B+) to subdivide the large group of advanced nurses. Level B+ involves nurses with qualifications surpassing their own department and nurses working as a consultant. Level C involves nurses that can do scientific research and can participate (pro-)actively in providing education and training.
The different levels and some competences will be presented schematically. Meanwhile, the Dutch government has provided a grant, to facilitate printing and distribution of this quality frame.
Conclusion: A quality frame has been developed, describing four levels of competences in palliative nursing care, based on national and international guidelines. Education programs can use the frame to develope curricula and to make sure that the quality of these programs are guaranteed.

PE 2.S99

Getting into pedagogy: Action research in the Macmillan Specialist Palliative Care Team, North Wales NHS Trust (East)

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Utilising an action research model, we report on an education project, focusing on the local team delivering specialist palliative care teaching. Team motto: 'Optimising learning to optimise patient care'.
Background: Education is an important priority for all Specialist Palliative Care Teams. It aims to empower other healthcare professionals to deliver high quality care to all patients in the palliative phase of any illness. Education programmes should be planned, delivered and assessed against the highest pedagogical standards in Higher Education.

Three elements are important:
- The educator should ideally be a practising clinician
- The educator should be suitably qualified in pedagogical principles
- It is imperative to cultivate a culture of continuous professional and team development.

Methods: "Action research is a reflective process of progressive problem solving led by individuals working as part of a "community of practice" to improve the way issues are addressed." It acts as a vehicle for change rather than simply a means of investigation. The basic structure is a cycle of: plan, act, observe, reflect. One cycle builds on the other resulting in a continuous, dynamic spiral of service improvement.

Aims:
- To review the current teaching portfolio of the team
- To scrutinise individual and team practice
- To implement steps building on current good practice.

Interventions ('Act' as per cycle) include regular update sessions on salient pedagogical principles, the introduction of individual teaching folders to aid professional development by regular use of structured reflective practice logs, and centralising teaching requests.

Following this, formal review of the enhanced teaching portfolio and individual folders will aid decision-making on future design of single sessions, and inform curriculum design of programmes of study. The structured approach locally will support the integration and coordination of Palliative Care education delivery across a wider arena.

PE 2.S100

Baby doctors in palliative medicine - Helping arrivals deal with departures

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We report on a novel induction programme that was developed to support junior doctors working in the local Specialist Palliative Care Team and Hospice.

Background: "Suddenly I was launched into a job where everyone was dying left, right and centre. And none of my friends understood as they hadn't done a job like this one." (Personal experience of a first year doctor).

Since 2005 the local team has had first year doctors rotating every four months. Recently, the potential psychological burden on very junior doctors working in Palliative Care has become apparent. We decided to evaluate the way we train and support junior doctors in our setting, then to revise and develop the support structure offered.

Methods: After consolidating observations from the literature and local experience, we scrutinised the perceived benefits and disadvantages of junior doctors working in our setting to inform future direction. This exercise showed the opportunity of clear benefits, but also a number of challenging potential disadvantages that may impact on patient care and psychological well-being of the junior doctor. To maintain the benefits we realised that we should compensate as fully as possible for the disadvantages. We proceeded to develop and implement a novel Induction and Training Programme. Salient aspects include an integrated approach and harmonising the Programme with the Foundation Curriculum. The 2 week induction period aims to equip the trainee with core skills prior to allowing them to assess patients unsupervised. The creation of a Psychological Support Supervisor aims to provide a structured, confidential support service away form clinical practice.

Conclusion: Local development includes regular review and improvement of the Programme, integration of unselected 'takes', and development of a research project into junior doctors' experiences in Palliative Medicine to assess the Programme's efficacy. Recent academic appointments locally will assist this agenda.

PE 2.S101

Literary fruits along the palliative way

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Aim: I have attempted to find a new and interesting way of talking about palliative care in my educational speaking and lecturing.

Methods: I took my favourite pastime, which is reading and a love of literature, in general. Over several years, I collected sentences, phrases and chapters from fiction (German: "Belletristik") which are related to palliative care.

During my lecture I talk about the books I have read, presenting these quotations with the thoughts and insights of authors, novelists and poets. Mixed in, there are also funny, juicier parts and creative ways of thinking. Educating happens by using the quotations and making connections to important aspects of attitude, skills and knowlegde of palliative care.

Results: During the last years, I have had the opportunity to hold these lectures many times. In the process, I continue to include my findings from new books in the lecture so it remains fresh and palatable - not the least for me in my preparations.

Conclusion: The lecture "Literary Fruits along the Palliative Way" has been held in numerous places in Austria in various contexts of educational speaking and lecturing. From the affirmative response, it seems that people are very interested in this type of presentation and find it appealing. It fascinates me how the things we love ourselves can hold such potential to please other people in similar ways.

PE 2.S102

International multidisciplinary course: Suffering in orthodox perspective

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Palliative care aims at relieving suffering through impeccable assessment and treatment of pain and other symptoms, psycho-social and spiritual care. Spiritual care has usually little time allocated in the PC curriculum.

Aim: To bring together clergy and health care professionals involved in palliative care to share experiences, deepen mutual understanding of roles and discuss the orthodox perspective on suffering.

Method: a two and a half days course was designed. Three plenary sessions on: pain (based on the total pain model), theological perspective on suffering and ethical dilemmas were each followed by case studies reflecting the issues from the plenary and were carried out in small groups. Participants were allocated to different groups for each case study session to maximise the interaction. Moderators trained in moderating focus groups were designated for each group. Raporteurs were summarising the discussions, themes that emerged, issues that generated consensus, disagreement points. After each case study session the whole group rejoined to present conclusions.

Results: 74 participants from Romania, Moldova, Greece and US attended the course representing doctors, nurses, theology teachers, priests, social workers. Debates where frequent but a common language was found. Evaluations of the course were highly appreciative. A working group was set up to research and prepare a Christian definition of Palliative Care as it was felt that western palliative care model coming from a mainly secular society is not responding to the spiritual needs of predominantly Christian societies. A funding proposal has been submitted. The theologian group has put together a proposal to include ministering for the dying as a separate seminar for theology students.

Conclusion: The training was a unique enriching experience with unexpected action outcomes. The interest it generated proved that spiritual care needs to receive equally attention. Multidisiplinarity was crucial.

PE 2.S103

Communication with the dying patient - Results of a controlled intervention study on communication skills in undergraduates

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Aim: To assess the effect of a four months intervention on
(1) factual knowledge in communication,
(2) feeling of preparedness for the palliative care setting,
(3) attitude towards death and dying.

Methods: A new palliative care curriculum for Undergraduates was implemented at Witten/Herdecke Medical School and evaluated (09/06-04/07). A total of 31 teaching units (TU=45mins) were delivered to 4th year medical students (n=15) during the course of 2 semesters. 10 units were devoted to communication teaching including a longitudinal 1:1 real patient contact module of four months. The intervention was controlled by 3rd year medical students (n=22). Asessment was facilitated by an 86 items online questionnaire in a pre/post/retrospective-pre design using the Thanaphobia Scale Assessment, Collett-Lester Fear of Death and Dying Scale and a Harvard palliative program questionnaire. Instruments were translated into German, adapted and re-validated by a delphi process and pretesting (Internal consistency 0,83-0,91). Retrieved data was statistically analysed with SPSS.16. 5-point-Likert scales were dichotomised and correlative analysis was performed using the 2-sided exact test for 2x2 tables for small samples (p-value < 0,05 considered significant).

Results: 84% of all students (n=31) did have contact with dying patients and 76% had experienced the death of a family member or friend prior to the intervention. Significant changes were found in the feeling of preparedness to care for dying patients (p=0,007), to break bad news (p=0,005), to handle emotions in patient contact (p=0,001) and to speak about advanced directives (p<0,001). No change in attitude towards death and dying was found during the intervention.

Conclusion: There is a need for systematic teaching in communication with dying patient for undergraduates as they have relevant contacts with dying patients during their studies and feel a need for training while effective concepts are available.

PE 2.S104

Interprofessional communication taught to German nursing and medical undergraduates in a seminar on palliative care needs of the elderly

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Aim: The seminar aims at
(1) improving specific communication knowledge concerning care of old people at the end of life and
(2) developing the communication skills of the participants, focussing on interprofessional aspects.

Background: Communication within the multiprofessional team plays an essential role in the patient centred approaches of Palliative Care and Geriatrics and is an asset both specialities take pride in. Therefore, multiprofessional modules recently have been implemented successfully in postgraduate courses on Palliative Care and Geriatrics. However, very little has been accomplished yet to implement the topic in the undergraduate education of Nurses and Doctors. Therefore, we developed an experimental seminar on interprofessional Communicaton and the needs of the Elderly at the end of life, taught by an interdisciplinary team to a group of German Nursing and Medical Undergraduates.

Methods: A randomized, single-blinded trial will be performed, measuring quantitative (information flow) and qualitative (empathy, dominance, etc.) aspects of communication. Videotaped case-discussions between single participants of different professions will be the focus of the evaluation using adopted OSCE-Instruments (Item-Rating, Global-Rating) for measurement.

Results: The results of the quantitative and qualitative data analysis and its conclusions will be presented. The intervention is still ongoing and due to be finished on the 15th of November 2008.

PE 2.S105

The clinical diploma in palliative medicine - A resounding success

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Aim: To develop, implement and evaluate a Clinical Diploma in Palliative Medicine for medical practitioners.

A grant was obtained from the Australian Government´s Department of Health and Aging to develop and pilot a clinical (non-academic) diploma in palliative medicine for non-palliative care specialists. The development included the formation of a steering committee with representatives from General Practitioner Colleges from Australia and New Zealand and specialist colleges, including Medical and Radiation Oncology and Pain Medicine.

This committee was then responsible for determining the optimal nature of the clinical exposure for trainees, designing a curriculum, accrediting training sites and

supervisors and deciding on assessment processes.
The Clinical Diploma program has now been been operating in Australia for 3 years , under the auspices of the Australasian Chapter of Palliative Medicine and has been awarded to medical practitioners of many disciplines. The training principles are readily transported to other countries and the Diploma is now available in Singapore and New Zealand as well.
A recent evaluation has confirmed that this is a popular and highly profitable educational experience.

PE 2.S106

Experience of a first 120 hours case seminar course over a two years period to train in palliative medicine in Germany

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In 2003 the German Medical Council (Deutscher Ärztetag) wished to further develop Palliative Medicine (PM) in advising for a new subspeciality. Following this a working group (WG) established itself in a German university city encompassing consultants of different specialities looking after terminaly ill patients. The WG enlarged itself with a nurse managing a hospice, a theologian and a lawyer. Since 2004 the working group offers on behalf of the Medical Council a basic course in PM for physicians. To date over 150 physicians have graduated from the programme.
Aim: A small group of graduates of the basic course wished to continue the training. In response to that demand the WG offered on behalf of the Medical Council a first 120 hours case seminar course which ended in October 2008. Besides aiming for the qualification in PM we wanted to find out how the participants felt about the course and what major benefits they would have had for their daily practice and themselves.
Methods: In 30 afternoon sessions of 4 units the 16 participants presented cases of their own practice for discussion under the guidance of a supervisor and a consultant in PM. In addition were offered conferences on ethical/juridical questions, filmed interviews with dying patients and a visit to a Palliative Care Unit. A special event was when a patient with motor neuron disease, who had founded a support group, volunteered to talk to the group shortly before he died.
Results: Besides gaining the required sessions to qualify in PM 3 main results appeared.
1. We are all mortals.
2. Our therapeutic possibilities are limited.
3. Do we know what our patients wish?
Conclusion: The course has had a huge impact on the participants not only professionaly but also personaly. The time frame of 2 years helped to change practice and specialy allowed personal growth. We are determined to find a practical solution to continue the initiated process like the foundation of a quality circle in PM.

PE 2.S107

Research and education in palliative care: A European perspective

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Aim: To identify and compare research and education in palliative care in seven European countries.
Method: During summer 2008 seven European countries (D, E, F, NL, B, ENG, Pl) participated in an inventory from the European project 'Best practise in palliative care in Europe'. The data collection consisted of expert interviews and a literature search. The inventory concentrated on some issues about research and education, namely if structured research programs are available, if research is funded, existence of chairs in palliative medicine/ nursing or availability of medical specialties in medicine/ nursing.
Results: The data delivered an diverse picture of what is available across Europe. Important items were among others, that palliative care is not a specialty in each country. Additionally were the financial regulations (governmental or non-governmental support) organised in different ways.
Conclusion: More in depth investigation about the research and education situation is needed. First results of this study show large differences in standards and finances. The EAPC needs to collaborate about a European standard for education in palliative care.
Keywords: Education, research, palliative care, Europe.

PE 2.S109

Education and expertise development in palliative care in the Netherlands

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Introduction: In order to give optimal and adequate palliative care, education and expertise development are important. In recent years, a growing amount of courses and programmes to train (further) (non)professionals involved in palliative care has come on. However, there is no overview of courses, educational programmes, and further structural educational activities for those (professionally) involved in palliative care.
Aims: To get insight in all kinds of structural educational activities in palliative care for non-professionals (informal carers, volunteers) and professionals (physicians, nurses, paramedics, workers in spiritual care).
Study design and methods: We planned to study relevant documents and interview key figures. Within these two methods we will focus on the following aspects: final attainment levels and competences as described in educational documents; educational methods to train the knowledge, attitudes and skills; experienced gaps, future plans.
Results & conclusions: The study recently started en will be finished in April 2009. Therefore, we will be able to present our results, conclusions and recommendations during the EAPC conference in May 2009. Based on the results recommendations on national policy level as well as on the level of the individual training (institutes) can be made.

PE 2.S110

Preparing prisoners to become palliative care supporters in and out of prison

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Aim: To improve palliative care in a maximum security prison through training of inmates.Inmates of prisons in South Africa are at increased risk of becoming HIV positive. Health care resources are available to provide care in the prison hospital for acute illnesses but with little support for chroninc conditions.
Method: A project was initiated with the Mangaung Maximum Security prison in Bloemfontien, Free State, South Africa, to build capacity in inmates to provide palliative care support for each other both in social contact sessions, in the cells, and in the prison hospital. All prisoners serve long-term sentences with some serving life-sentences. An assessmen tof needs was carried out and a professional nurse tutor employed by the prison, trainined as a trainer in palliative care and home-based care, and supported to provide training to inmates as part of their skills-development programme. Inmates who successfully completed the 3 month course received a certificate from the local hospice, St Nicholas Hospice, as completing the national training course for home-based caregivers. Certain inmates are permitted to work in the cells and in the prison hospital. Reports are given of support given between prisoners , and certain have received further training in counselling. Prison staff receive in-service training on the impact of grief and loss on the inmates and their behaviour, which has led to better understanding of the prisoners needs by staff.
Results: The project started in 2001 and to date 580 inmates have been trained, some of whom use their certificate to gain employment after release. the inmates work as trained volunteers supporting each other and the prison health service.
Conclusion: Prisoners can become an effective part of a palliative care service in prison with training, supervision and support.

PE 2.S111

Effects of a multi-professional course for paediatric palliative care (PPC) in Germany

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Background: PPC is complex and requires the collaborative involvement of health care professionals from a variety of backgrounds. To adequately teach those professionals, a 200 hours core curriculum for multiprofessional PPC courses was developed in Datteln, Germany.
Aim: We aim to determine the effectiveness of the course with regards to the participants' level of knowledge and confidence in PPC and their educational needs. Also we want to establish the impact of the course on the personal, professional and team related developments of the participants.
Methods: The study has a quasi-experimental design with pre-posttest measurement and is partly triangulated. We used two questionnaires to obtain pre- and post-scores on the level of knowledge, self-confidence and educational needs (quantitative analysis). The expectations concerning the PPC course and the perceived changes during the course were explored in focus group interviews and analysed by thematic analysis (qualitative analysis).
Results: 40 professionals (three courses 2007-2008) were recruited for the study. Statistical analysis established an increase in knowledge and self-confidence. Analysis of qualitative data revealed that all professional groups benefited in various ways from the multiprofessional approach. The benefit was perceived as
(1) an increased understanding of the complexity of PPC,
(2) a chance for the reflection of own competencies, responsibilities, insight,
(3) increased self-confidence as part of a multiprofessional team and
(4) development of a nationwide network.
Some participants (especially physicians) required teaching units for each professional groups, to discuss specific aspect and gain deeper knowledge.
Conclusions: The findings indicate effective outcomes of the multiprofessional PPC course. Qualitative analysis identifies new aspects which have to be considered in further developments of PPC curricula.

PE 2.S112

Palliative care by the general practitioner in Flanders: The HiPP-project

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Aim: General practitioners play a crucial role in the delivery of good palliative homecare. They need a lot of knowledge and skills essential for offering quality in palliative and end of life care, they need to organize continuity, they have to stimulate and to coordinate the interprofessional homecare team. In too many cases these conditions are not reached.
Methods: A Working Group within the Scientific Organisation for General Practitioners in Flanders created, inspired by the success of Golden Standards Framework in the UK, a innovative programme allowing at the end all GP's in Flanders to offer a basic (golden?) standard palliative care for palliative patients. The programme is based on 7 essential core tasks required for good palliative home care. Another important characteristic of this programme is the open learning aspect: the programme is ICT, e-learning based combined with well-planned facilitation sessions. The implementation happens in different phases.

During the first one 2 teaching practices acted as pilot cells: they received e-learning material and life facilitation sessions around 4 of the core tasks: pain- and symptom control, communication, coordination and care of the dying. For the facilitation sessions a script including tasks and assignments is written down, facilitators were trained.
Results: Two master students general medicine studied outcome and process of the first implementation phase.Their findings will be offered in detail.
Conclusion: The main conclusion is that this programme sounds very promising. Enlarging the programme implementation in the second phase to more various types of practices (solo practices, group practices, GP's with a coordinating task in homes for elderly etc.) seems legitimate. Palliative care being essentially an interprofessional team event makes the future timing when to extend the programme to other professional caregivers as nurses and social workers very important.

PE 2.S113

Diagnosing dying - A neglected topic in medical textbooks

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Aim: It is evident that recognising dying is fundamental for good end of life care. Therefore it is of interest whether medical doctors are being taught how to do so within their studies. This paper focuses on the way in which issues of death and dying are approached in textbooks as basic reading for medical students.
Method: A representative sample of recommended medical textbooks (n=40) for medical students at universities in Austria and Germany was analysed. The sample covers nine different medical disciplines at six different universities with books in both German and English. The focus of the analysis was to find out whether dying is defined, which factors are mentioned to determine dying and whether there are references to palliative care or not.
Results: Issues of end-of-life care are covered in medical textbooks, though they only form about 1% of all pages in each book on average and 2% at most. Contents differs between the subjects: Surgery seemed to be focussed on issues of indication with regard to a cost-benefit analysis of a certain intervention. Internal medicine and oncology instead covered a broad range of issues, and listed a broad number of more or less specific symptoms of dying. The latest issues of textbooks include a growing amount of information about palliative care. Palliative medicine, finally, provides the context for the most elaborate debate of how dying can be "diagnosed", though even this discipline seems to lack a specific definition of dying.
Conclusion: Though palliative medicine is becoming an accepted specialty in German speaking countries, end-of-life care, especially diagnosing dying, is still a neglected issue in medical textbooks. This also shows that dying is a complex phenomenon and its beginning and "definition" is difficult to grasp on clinical grounds alone. To close this gap, references to other disciplines to cover spiritual, social and psychological issues are required within medical textbooks.

PE 2.S114

Withdrawn

PE 2.S115

SENTENCE - Which of diagnosis is a "sentence"? The comparative study of attitudes towards different chronic diseases

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Background: Palliative care (according to WHO) is the active holistic care of patients with advanced progressive illness. In spite of increasing number of patients suffering from chronic diseases ,they don't get sufficient supportive care. Palliative care is still mainly given to cancer patients. Is it still a true that the diagnosis of cancer sounds like a 'sentence' - a disease that inevitably leads to death? Or do we find other disease to be more charging than cancer?
The aim of the study was
• To evaluate which chronic diseases are mostly considered to be a 'sentence' and what conditions may correlate with this attitude.
• suffering from different chronic diseases.
Material & methods: Self-made questionnaire of 17 questions was prepared. The questions concerned people's individual opinions and feelings about 15 selected chronic diseases.
We surveyed the group of
a) 134 students
b) 57 teachers and office workers (almost 65% of them have higher educational level).
Results: Cancer (80,6% of students; 73,7% of 40-year-olders), HIV/AIDS (81,3%; 68,4%) and multiple sclerosis (35,1%; 26,3%) are mostly claimed to be a 'sentence' in both groups. These diseases are mostly associated with greatest suffering and poorest prognosis.
Both students and 40-year-olders indicate as less tolerated disease HIV/AIDS - 91,8%, 87,7%; schizophrenia 54,5%, 52,6% and epilepsy 36,6%, 38,6 respectively.
Conclusions: Cancer and HIV/AIDS are still believed to be a 'sentence'. Respondents found these diseases cannot be altered by any treatment. The word 'sentence' is mostly related to the poorest prognosis and the greatest suffering due to the disease.

PE 2.S116

Dissemination of research results over the internet - A web-based anthology of palliative care

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Generic palliative care is increasingly considered an essential part of meeting the needs of diverse groups of end-of-life patients. For this reason, it is particularly important to increase the body of palliative care knowledge and disseminate it to personnel in a variety of elderly care contexts. The Swedish research institute, Vårdal Institutet took the initiative to set up a virtual room with the theme of palliative care in Sweden, as part of a larger project encompassing eight virtual rooms with diverse health care themes. The aim of this presentation is to give an overview of the virtual thematic room for palliative care and issues related to the dissemination of knowledge to staff involved in elderly care. The virtual room presents reviews of recent research organized into the following themes: palliative care, relief of symptoms, life issues, significant others, and team work. The room also contains articles on each theme written by experts for the general public. Twenty of these are currently available for download and there are more being published all the time. In addition to these articles, the room contains palliative care news bulletins and reference lists for text books, dissertations, fiction and biographies, and books for children. The "current profile" and "good example" presentations are constantly updated. As this particular website is part of a larger virtual project, links and references to related issues such as "Living with chronic pain" and "Nutrition and eating" can easily be created, The virtual room also suggests syllabuses for palliative care workshops intended for the further education of elderly care personnel and others, and these syllabuses make use of the articles published on the website. In conclusion, the virtual thematic room is a flexible, web-based anthology of interest and relevance to a wide range of readers interested in palliative care.

PE 2.S117

Withdrawn

PE 2.S118

Educational training in palliative medicine - The experience of the University of Turin

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For the academic year of 2008-2009, The University of Turin has reactivated the IV Master's programme in Palliative Medicine.
The main objective is to train professionals to operate in the field of Palliative Medicine, giving them the necessary skills both from the general and specific point of view. Attention will be paid not only to oncologic pathologies, but also to neurological, cardiologic and respiratory pathologies as well. The emphasis will be on equipping the students with the theoretical and practical preparation that will allow them to acquire the knowledge and skills demanded by the opportunities opening up in managed care facilities and hospice structures at both the Regional and National levels.
Master will be held by 79 university professors and experts, already involved in previous editions, particularly skilled in palliative medicine.
Seventy-two Master's degrees have been awarded since 2002.
The duration of the Master's Program is two years and is equal to 60 CFU (University Formative Credits). Credit attainment is subordinate to the passing of periodic tests and exams intended to verify the levels of competence acquired. The awarding of the Master's degree depends on the writing of a successful final thesis. Attendance is mandatory.
The training areas are delineated as follows:
- Bioethics at the end of life
- Cultural and Social anthropology
- Neuroscience
- Clinical problems in Palliative Therapy
- Quality and research in Palliative Therapy
- Motivation and training of personnel
- Programming Palliative Therapy
The course is open to all graduates in Medicine and Surgery.
Graduating students will be admitted at registration provided they attain their degrees before the course begins. The minimum number of participants is 15, the maximum is 30.

PE 2.S119

Palliative sedation in the Netherlands: A lesson for professional caregivers

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Aims: Palliative sedation is a last resort option for terminal patients with refractory symptoms. The national Dutch guideline states that the use of palliative sedation should be limited to patients with a life expectancy of two weeks at most, but such a prognosis is often very difficult to ascertain. Further, the distinction between palliative sedation and euthanasia is often unclear for patients, families and also professional caregivers, which may result in uncertainty, miscommunication and sometimes abuse of palliative sedation. Efforts to enhance the distinctness of this practice by increasing knowledge and awareness of the criteria in the guideline are therefore needed.
Methods and results: The Committee on Quality and Development of Consultation of the department of Palliative Care of the Comprehensive Cancer Centre Rotterdam (CCCR) has developed a lesson on palliative sedation. The aim of the lesson is educating both physicians and nurses on the assessment of refractory symptoms; on the aims, techniques and possible effects of both temporary/intermittent sedation and continuous deep sedation until death; and on communicative aspects. The lesson takes 3 hours and is given by a consultant-physician and a nurse. The CCCR provides train-the-trainer courses for these consultant-physicians and nurses in order to have experts in every network in our region.
The lesson is given 28 times in 2008, and is evaluated by asking trainees about their experiences. The results of the evaluation will be available in 2009.
Conclusion: Multidisciplinary educational efforts that use palliatieve care networks and a train-the-trainer approach potentially reach a large group of professionals and organisations at once. This can result in better communication between caregivers and a less ambiguous practise.

PE 2.S120

Palliative care in the ITU - The intensivist perspective

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Aims: Palliative Medicine is a growing specialty with a non-malignant agenda becoming more prominent. This has seen the palliative perspective expand into

acute settings, an example of which is the recognition of the need for good quality end-of-life-care (EOLC) in Intensive Therapy Units (ITU). By identifying the differences and challenges of providing EOLC the researchers hope to enable improvement in palliative care in the ITU.
This study aims to explore in depth the ITU teams' opinions of the difficulties of providing palliative care in an Intensivist setting. Specific topics to be explored include:
- Difficulties of providing EOLC in ITU;
- How palliative patients are identified;
- Communication within the ITU;
- Involvement of family;
- The development of Palliative Medicine in ITU.

Methods: This was a qualitative interview based study utilising the "general interview guide approach", as described by Patton. All recorded interviews were analysed with a qualitative content analysis package. To increase validity transcripts of interviews were returned to a 60% sample of the interviewees for review.
Results: 25 interviews were completed. Generally teams felt communication and symptom control was of a good standard, and that the ITU had a number of advantages over general wards in provision of EOLC, specifically availability of anaesthetic support and good nursing ratios. However the majority of staff felt poorly educated in palliative care and many felt that patients often underwent unnecessary interventions prior to death. There were also a number of issues surrounding environment, decision-making and continuity of care within ITU.
Conclusion: The provision of palliative care in the ITU presents unique challenges not found in other settings. While staff felt ITU is not an ideal setting for EOLC for a variety of reasons, they also presented a number of advantages to its provision there. Areas for further examination include decision-making and education of the ITU team.

PE 2.S121

Prime tasks of our palliative consulting team at the Wilhelminenhospital in Vienna: An evaluation from september 2007 - august 2008

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Background: The Palliative Consulting Team at the Wilhelminenhospital, a medical center with 1092 beds, was established to meet the special needs of patients with advanced and incurable diseases, and to support caregivers in all problems and issues.
Methods: Between September 2007 and August 2008, we evaluated the most important tasks of a palliative care consulting team in hospital.
Results: Results showed that the main tasks were to attend to patients and their families, to regularly adjust the treatment concept, to inform, to guide and organize within the framework of discharge, to control symptoms, advance other units, communicate with and within the care team and help fulfill patients' last wishes. Most of the patients observed in this period suffered from 8 to 18 symptoms. The most prominent were weakness, fatigue due to tumor anemia, loss of appetite, dry mouth, depression, anorexia and pain. At the time of initial evaluation 30% of the patients suffered from pain at level 4 on the numerical rating scale. Due to intensive cooperation with mobile palliative care teams and social bases it was possible to discharge 46% of all palliative care patients. 18% of the palliative care patients were accommodated for further care to a hospice or a palliative care unit. A palliative home care team was organized for 74% of the patients. The Palliative Consulting Team provided much internal and external training hence succeeding in making the way of palliative thinking more transparent.
All of the patients visited were made aware of the possibility to express their last wishes to maintain the patients' highest possible autonomy.
Conclusion: In conclusion, our main goals were to elevate the standard care of terminally ill patients and their families by contributing our expertise, the improvement of pain therapy and symptom control and to advise care givers in complex situations of palliative care and ethical issues.

PE 2.S122

A longitudinal study of the prognostic role of quality of life factors on length of survival of terminal cancer patients receiving palliative care in Taiwan

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Aim: This study, one of only a few to do so, explores the significance of quality of life parameters for predicting length of survival of patients with terminal cancer.
Methods: Weekly assessment of 180 terminal cancer patients was carried out throughout their survival time using the (Medical Outcome Study) MOS 36-Item Short-Form Health Survey, the Taiwanese version of the M.D. Anderson Symptom Inventory (MDASI-T), the Karnofsky Performance Status (KPS), the Brief Pain Inventory and the Brief Fatigue Inventory. Generalized Estimating Equations were utilized to account for the dependence of repeated measurement and to analyze whether the quality of life parameters predicted survival time.
Results: The univariate analysis showed that gender, KPS, the Physical Component Summary (PCS) score, the MDASI-T total score, composite fatigue severity, and composite pain severity were significantly associated with length of survival of terminal care patients. Moreover, the univariate analysis showed that most items in the MDASI-T were also related to survival time. In the final model, the multivariate analysis showed that gender, KPS, and the MDASI-T total score were significant predictors of survival time.
Conclusions: This is the first study to explore the prognostic significance of quality of life parameters to length of survival of patients with terminal cancer using information collected weekly throughout the terminal phase and employing the GEE method to account for the dependence of repeated measurements. While traditional analytic methods suggest prognostic significance of quality of life parameters, this study confirms that overall symptom severity and functional status are the strongest factors in assessing the length of survival of terminal cancer patients.

PE 2.S123

Knowledge and attitudes of intellectual disability and palliative care by specialist palliative care teams and ID carers in Kent

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People with intellectual disability (ID) have been shown to have increased health and palliative care needs as they grow older, including progressive diseases such as cancer, heart and respiratory disease and dementia. There is evidence of limited palliative care provision for ID patients.
Aims: The aim of these two studies was to investigate the knowledge and attitudesof both specialist palliative care providers of ID and paid carers of ID of each other´s specialism, with the objective of delineating whether such attitudes or systems reduce the palliative care of people with ID.
Methods: A series of focus groups were held with specialist palliative care teams and formal carers of people with ID to ascertain their knowledge, perceptions and attitudes of ID and palliative care services.
Results: The data showed that involvement of specialist palliative care services for people with intellectual disability was small. Palliative care specialists expressed the view that their training and knowledge of this patient group is also low, resulting in anxieties as to how to adequately care for this patient group.
Similarly there was also little understanding of palliative care services by ID services, and carers shared concerns that palliative care services may not always wish to or were not always appropriately able to care for people with ID.
Conclusion: Shared education of specialist palliative care providers and ID carers is necessary to increase mutual understanding, so that care can be provided in a collaborative way. Whilst there may be no obvious discrimination against these patients there is a need for greater awareness of ID amongst staff, at all levels, so that the needs of people with ID can be addressed adequately, and appropriately. The development of links between teams was felt to improve liaison and understanding, with the aim of improving the quality of life of ID clients with progressive disease.

PE 2.S124

Medication at the end of life for motor neurone disease

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There has been increasing pressure to provide palliative care for people with MND/ALS. There are many fears of patients and their families about the final stages of the disease progression and professional carers often fear the use of medication, in particular opioids.
Aim: This study aimed to show the medication used within specialist palliative care units in the end of life care for people with MND/ALS.
Methods: A questionnaire was developed to record medication given to patients with MND/ALS in the last 72 hours of life, together with basic information about the patient and disease progression. Six hospices in the UK and Ireland agreed to complete the details of the last 10 patients who had died under their care in the hospice.
Results: 60 patients were analysed and the results show that medication is usually necessary in the control of symptoms at the end of life. These are commonly morphine as analgesic, midazolam as sedative and muscle relaxant and glycopyrronium bromide to reduce lung secretions.
Discussion: Many patients with MND/ALS, their families and carers and often the professional carers fear the final stages of the progression of MND/ALS - fearing in particular pain, dyspnoea and choking. These results show that the medication used at the end of life to manage difficult symptoms does not differ greatly to those used with other conditions. People with MND/ALS, their families and health professionals can be reassured that after appropriate symptom assessment the careful use of opioids, and other medication, is helpful and appropriate at the end of life. The symptoms at teh end of life can be effectively and appropraiately managed similarly to other patient groups receiving palliative care.

PE 2.S125

Predictors of home death among palliative cancer patients in a primary care setting

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Background: In most western countries, the majority of palliative cancer patients wish to die at home, where GPs are often deeply involved. However, most research focuses on specialised palliative care, which results in a lack of reliable predictors of home death in primary care.
Aim: To analyse predictors of home death among deceased palliative cancer patients in a primary care setting.
Methods: Using Danish registers, we identified 787 deceased cancer patients and sent a questionnaire to their GPs. The questions concerned the GPs' involvement and the duration of the palliative period at home. We analysed the data using a model adjusted for confounders (e.g. patient's sex, age, marital status, type of cancer), with independent variables such as the GP's knowledge of the patient prior to the palliative period, whether the GP had made home visits, whether the GP had planned who to contact out-of-hours, and whether the GP had had contact with the relatives.
Results: 350 questionnaires were filled out. In the preliminary analysis we found that even though many patients died in hospital, this group spent nearly as much of their last time at home as the patients who actually died at home. The analysis of the GPs' involvement is still ongoing.
Conclusion: The results of GP involvement in home death will be presented. More specific research concerning palliation in primary care is still needed.

PE 2.S126

Identifying professional barriers and facilitators to discussing future care and preferred place of death with patients who have advanced cancer

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Aim: UK end-of-life care initiatives recommend that the preferences of patients with advanced cancer and their families inform care planning. Advance Care Planning (ACP) may help achieve this. Therefore we piloted the implementation of an ACP toolkit based on the UK Gold Standards Framework (GSF) documentation and to identify key issues for general practitioners and community nurses in talking with patients and families about their future care, including place of death.
Methods: We recruited four general practices in South East Scotland. Semi-structured interviews (n=28) with practitioners and community nurses in these practices identified current practice, and key issues in discussing end-of life care. An interactive training workshop in ACP and the use of the pilot toolkit was then conducted at each practice. Three months after the intervention, we re-interviewed the participants (n=25) in order to identify the issues that they encountered in implementing ACP and to reflect on the training. Transcripts of the interviews and workshops were entered into the qualitative software package NVivo 7 and analysed thematically.
Results: All participating practices had a palliative care register in line with the GSF but structured ACP was rarely being undertaken. Clinicians reported anxiety over the wording and timing of discussions about end-of-life care which, if they occurred, were often triggered by a decline in the patient's condition. Before the intervention, clinicians had almost no knowledge about ACP documents. The intervention and follow-up revealed a significant mis-match between clinician understandings of when to start an ACP and GSF recommendations that will need to be addressed.
Conclusion: This study refined our intervention (toolkit and training) for a planned larger trial that will include the perspectives of professionals, patients and carers. The findings will be of interest to those planning similar studies or service developments.

PE 2.S127

Evaluation of the quality of palliative care in stationary hospices from the perspective of patients/their families and those performing the care

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Aims: The aim of the research was to evaluate the quality of palliative care in the stationary hospice. Finding recommendations for a strategy of the care quality improvement was an indirect aim of this research.
Methods: The research was realised between March and August 2008 in a stationary hospice in the Mazowieckie Voivodeship. The research group comprised of 120 people - 20 people performing professional medical care, 50 patients and their families, and 50 students of the Warsaw Medical University.
Results: As regards the hospice, the expectations of the families are that: the patient will not suffer (85%), he/she will feel safe (80%), and will receive spiritual support (61%). At the same time, 85% of the group stated that their expectations are fully fulfilled by the stationary hospice. For 47% the patients´ families, the biggest problem in a hospice is their own inability to perform such care (47,6%) and their helplessness (38%). In the opinion of 8% of the students, 47% of the patients´ families and 14% of the employees, the patients are very pleased with their stay in a stationary hospice. According to 48% of the students and 85% of the medical personnel, the quality of the care on the ward would significantly rise if the medical team was larger, medical care nurses were employed (57%vs85%), more time was devoted to patients (14%vs16%), and free time activities were organised for patients (16%vs25%).
Conclusions: According to most respondents, the patients are satisfied with the stay in a stationary hospice. Nearly half of the patients´ families think that, for them, the biggest problem is their own inability to take care of the patients. For the personnel the work in a hospice is a physical and psychical burden. Therefore one should consider the possibility of enlarging the employment - concentrating on hiring medical care nurses.

PE 2.S128

´What evidence is there about the specific environmental needs of older people who are near the end of life and are cared for in hospices or similar institutions?´ A literature review

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Background: In Western countries, an increasing proportion of patients requiring palliative care are aged over 65 years. However, very little is known about the type of physical environment most suitable for their care.
Aims: To conduct a literature review addressing the question: ´what evidence is there about the specific environmental needs of older people who are near the end of life and are cared for in hospices or similar institutions?´
Method: The BNI, CINAHL, Cochrane Library, Medline, Proquest, PsycInfo, SocSci Citation Index, Social Care Online and ASSIA databases were systematically searched for papers meeting the inclusion criteria (published after 1997; relating to the physical environment of care for in-patients over 65 in the last year of life). Four key journals were hand searched. Relevant references were followed up.
Emerging findings: 16 papers met the inclusion criteria, although 15 of these only mentioned the physical environment briefly. Ten of the studies were conducted in nursing homes, and none were in hospices. Only six studies included the views of patients; the others sought the views of families and professionals. Several themes were identified:
(1) ´Homeliness´: Older people wanted to personalise their own space, eg with photographs, ornaments and religious symbols.
(2) Privacy and Quiet: Single rooms were preferred by most patients and families. Excessive noise was viewed negatively.
(3) Access to the outdoors: Patients and families valued accessible outdoor spaces, and rooms with windows giving sunlight, fresh air and interesting views.
(4) Staff Needs: Buildings were not always designed to allow staff to work safely and efficiently.
Conclusion: In some cases, relatively simple changes to the physical environment might enhance quality of life for older patients at the end of life. However, other adaptations might be more difficult and costly, and it is important that they are preceded by thorough research into stakeholders´ needs.

PE 2.S129

The impact of poor coordination of community service provision on end of life care for patients with cancer

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Background: Providing service users with a say in their care is integral to UK government health policies. For patients dying of cancer there is an emphasis on giving choice regarding their preferred location for care, which includes the option of dying at home. Initiatives such as the End of Life Care Programme that promote patients choices including their preferred place of death the have been established However despite these policies the situation persists where patients are being admitted to hospital in the terminal phase of their illness when they have expressed a desire to die at home.
Aim: The study aimed to investigate the views of community nurses involved in end of life care for people with cancer in an attempt to explore the factors that influence where they are cared for and ultimately die.
Methodology: A qualitative study, using audio tape-recorded focus group interviews was employed for the study. A purposive sample of 19 district nurses and community specialist palliative care nurses from across two primary care trusts in the North West of England participated in two focus groups. Data were analysed for emerging themes using thematic analysis.
Results and discussion: The findings of this study suggest that poorly coordinated service provision impacts upon enabling patients with cancer, who wish to die at home to achieve this goal. Poor discharge planning from the hospital, including a lack of communication with the community nursing team, coupled with delays in commencing additional care services and the delivery of equipment are all identified as influencing factors. This paper discusses these findings and recommendations for improving the services offered to terminally ill cancer patients and their families will be given.

PE 2.S130

The management of diabetes mellitus in pallaitive patients including patients on the Liverpool Care Pathway for the dying patient

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Aim: Identify management issues in diabetic palliative care patients including patients dying on LCP.
Background: The current prevalence of diabetes mellitus is 2-4%, which is reflected in the patients encountered by palliative care services.
Methods: An audit of palliative care patients with diabetes in all palliative care settings.
2 questionnaires were created.
First sent out to all clinical palliative care specialists assessing current number of patients affected by diabetes and their management.
Second prospective questionnaire examining management of diabetic patients on LCP.
Results: 96 responses from all clinical palliative care specialists including allied health professionals received from questionnaire 1.
60% had ≤ 10 diabetic palliative care patients.
Sulphonylureas main hypoglycaemic of choice.
35% using short acting insulin for management of hyperglycaemia.
7 responses received for questionnaire 2.
All patients were Type 2 Diabetics whose hypoglycaemics stopped once LCP started. Majority of patients had not discussed their diabetic management prior to starting LCP. Only 10% of patients and carers were given information regarding diabetic management once LCP started.
Conclusion: The key recommendations include:
- The need to discuss management and relaxing of diabetic medication of diabetes with patient / family as oral intake declines and before patient is started on LCP.
- Sliding scales of insulin should not be used.
- Early specialist advice from PCT and Diabetes specialists should be sought if
1. Patient symptomatic from hyper/hypoglycaemia
2. Diabetic complications
- If dying and unable to take fluids /medication, stop oral hypoglycaemics/ insulin in Type 2 diabetes.
- Terminal phase in Type 1 diabetes - may be worth considering maintaining patient on insulin at reduced dose to limit risk of symptomatic ketoacidosis.
- The results of this study will form part of the Merseyside and Cheshire palliative care network guidelines.

PE 2.S131

A survey of experiences and views of doctors working in an Irish teaching hospital to prognostication

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Aims: The aim of this study was to explore the knowledge and attitudes of doctors in an Irish teaching hospital to prognostication. This study was conducted in order to inform development of strategies to advance patient care and medical decision-making through improved accuracy and communication of prognostication.
Methods: Questionnaire development was informed by a review of the literature. The target population consisted of all doctors working in St Vincent's University Hospital, except those working in specialities associated with minimal likelihood of caring for patients with advanced disease. Survey distribution was conducted using an individualised approach.

Results: Sixty-two doctors returned the completed questionnaire (response rate 35%). Junior doctors receive requests for estimation of survival from patients and relatives as often as senior colleagues, but are less likely to have a pro-active approach to disclosure of prognosis to patients. Patients' family members request information regarding prognosis more frequently than patients, however the doctors surveyed respect the patient's right to control what information their relatives and they themselves receive. Doctors under-recognise the precedence of the prognostic value of signs and symptoms during the period of terminal decline and have limited acknowledgement of the prognostic relevance of performance status in all patients with metastatic incurable cancer. Professed attitudes suggest ambivalence over disclosure of prognosis; whilst there was considerable agreement with the need for patients to have access to accurate information regarding prognosis, the majority (69%) believe that the communication of prognosis to patients may itself have an impact on survival.
Conclusions: A teaching program which targets the identified gaps in knowledge, encourages consideration and debate of the issue of self-fulfilling prophesy and provides practical training on communication of prognosis should be developed.

PE 2.S132

The role and involvement of the specialized supporting health service "LEIF physicians" in end-of-life decision making in Belgium

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Aim: In 2003, after the euthanasia law was passed, LifeEnd Information Forum (LEIF) was founded in Belgium to train physicians to consult, advice, and inform about end-of-life care decisions and euthanasia. So far,evaluation of this supporting health service is lacking. This study describes number and content of requests LEIF-physicians receive in a one-year period, including palliative care related issues.
Methods: All 128 active LEIF-physician were sent a questionnaire asking about demographics, training in end-of-life care, and consultation and information requests from May 2007-May 2008.
Results: Response percentage was 75%. 73% of respondents were GP, 26% were part of a palliative care team, 41% followed postgraduate studies in palliative care, and 72% had some form of additional palliative care training.
In one year they received 2518 requests for information by patients mostly about living wills (n=656), the legal procedure of euthanasia (n=623), palliative care (n=533), and 1491 requests by physicians, of which 37% (n=545) was about the legal procedure or practical performance of euthanasia.
Respondents were contacted 550 times for consultation with attending physician and patient regarding a specific end-of-life decision. Of these cases 65% ensued from a patient request for physician-assisted death, and for 57% (n=311) an actual consultation as a second physician as prescribed by the euthanasia law was made. All due care criteria were judged to be met in 284 cases (91% of actual consultations); 219 of these cases (77%) ended in euthanasia.
Conclusion: LEIF-physicians are more often consulted by patients than by physicians. In these, patients address a broad spectrum of end of life issues, including on palliative care. Physicians mainly contact LEIF-physicians for concrete information about euthanasia and for actual consultation as second physicians in cases of patients requesting euthanasia in order to reach a well-considered decision.
Funded: IWT-Flanders.

PE 2.S133

Mortality in the dialysis population - When should termination be considered?

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Inherent to the rise in the number of patients on dialysis is an increase in the number of patients dying on dialysis. Despite this high mortality there is a paucity of literature on the process of dying in this population.
Aim: The aim of our study was to profile this group and identify factors suggesting end of life which may be used as predictors for those who may benefit from termination of dialysis.
Methods: A retrospective review of all deaths in patients on dialysis in St Vincent´s Health, Mebourne, over a two year period from March 2005 to February 2007 was undertaken. Patients dialysed continuously for three months or more were included. Those considered for transplantation were excluded. Patient demographics including co-morbidities, whether the death was expected, specialist palliative care involvement, place of death, and factors influencing the decision to terminate were collected.
Results: There were 78 deaths during this period, an 18% annual mortality. The mean dialysis duration was 33 months. The majority of deaths occurred in acute hospitals (81%), with only 14% dying in specialist palliative care units. Only four patients (5%) died at home.
90% of deaths were expected, yet of these termination was chosen in only 25%. Specialist palliative care team was consulted in 29% of patients, usually within two days of death.
The average duration between last dialysis and death was 2.13 days for all patients, but in those for whom dialysis was terminated, time to dying was 5.67 days (3-17). The average final in-patient admission was 23 days.
Conclusions: Our study confirmed a high mortality. It also showed predictability of death, but despite this the majority of patients did not benefit from the comfort of termination. Prolonged hospital admission, advancing age and a comorbidity of ischaemic heart disease are all positive predictors for death. The trajectory of life following dialysis cessation is very variable.

PE 2.S134

Preferred place of care for people with intellectual disabilities (ID) who are terminally ill

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Aims: To explore issues around assessing the needs of people with ID who have been diagnosed with a life-limiting illness, in order to establish preferred place of care.
Methods: This paper is based on the findings of a 3 year ethnographic study of the experiences of people with ID who have cancer. Data were mostly obtained through extended participant observation of the person with ID, including conversations with family and carers. The needs of 13 people with ID and cancer were analysed.
Findings: The findings will be presented through the stories of 3 participants. The focus of assessment should be the person's life story and quality of life, and the impact of illness and physical deterioration. Important aspects of assessment include: the person's place in his/her family; their care history; the important areas in their life, including areas of enjoyment; available support; current health needs and anticipated future health needs, including pain and other symptoms; insight and understanding; and issues around capacity and consent.
Conclusion: No assumptions can be made about preferred place of care. Needs can change frequently and rapidly. The end-of-life care needs assessment of people with ID is complex. The expertise and involvement of primary carers is crucial, but this should be supported by professionals who can give support to both the person with ID and his/her carers and family.

PE 2.S135

The end-of-life experiences of people with intellectual disabilities (ID) who have cancer

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Aims: To gain insight into the end-of- life experiences people with ID who have cancer, from their own perspectives.
Methods: This was a 3 year study, using ethnographic methodology and Grounded Theory. The participants were 13 people with ID ranging from mild to severe who had a cancer diagnosis. Most (11) were terminally ill, and 9 died during the course of the study. Data collection methods consisted mainly of prolonged periods of participant observation.
Results: It was important to look at each person's life story before their experience of cancer/terminal illness/dying could be understood. The lives of the participants were defined by their dependence on others. Features of their cancer journey included late diagnosis, and a lack of involvement in decision making around treatment. Social networks were mostly poor. Families (in particular parents and siblings) were an important part of participants' support network. Paid carers, especially those in residential homes, had a difficult task and needed much support.
Conclusion: High quality end-of-life care to people with ID requires the presence of warm and empathizing carers, combined with competent symptom control and support for the carers. This was not achieved for any of the research participants.

PE 2.S136

Hospice home visits of the Regional Hospice Centre Zagreb

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The aim of this report is to show the basic structure of patients that have been in the care of Regional Hospice Centre Zagreb on the voluntary basis.
The data listed here refer to the period from September 2005 till February 2008., and the data were tkken from our book evidence.
The patients are listed according to their age, sex, diagnosis, leading symptoms, the way of coming into the center, the period of waiting for the first visit, the place of death. There were total of 520 patients in our care: 288 women and 232 men.
The majority of patients were between 70 and 80 (total of 130, 75 women and 55 men).
According to the diagnosis the majority of patients had lungs cancer and bronchial cancer (total of 82, 60 men and 22 women). The number of women with breast cancer was 42 and the number of women with gynaecological diseases was 40.
The patients have been waiting for the first home visit for 1 to even 20 days (some of the patients died before the arrival of the team and some were taken back to hospitals by their families).
The main symptom and the main reason for calling the palliative care hospice was pain i.e. inadequate analgesia, sub-dosage, irregular taking of analgesics, avoiding morphine substances and very often application of fentanile sticking plasters with no effect.
The average period of care has been about 50 days.
The most frequent place of death is the home of the patient (for those who have longer been in care), hospital (for those who came late) and in Old People´s Homes and other institutions for care and nursing.
Conclusion: We have met a very complicated cases in our work.
In order to be able to fulfil the needs of patients in the end of life and to help their families we need PC integrated in the health system. It is necessary to have teams who would work full time (the patients shouldn´t wait for the doctors-volunteers).

PE 2.S137

Use of a multidisciplinary institutional protocol on continuous palliative sedation until death based on the Dutch guideline 'Palliative Sedation'

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Introduction: In the Erasmus MC a multidisciplinary protocol for continuous palliative sedation until death (CPS) was developed. The protocol was based on the Dutch guideline 'Palliative Sedation', in 2005 launched by the Royal Dutch Medical Association. The protocol is written as a checklist. At start, the patient's current state has to be clarified. Next, the conditions for palliative sedation have to be checked by tick box items. In case of a medical indication for CPS, care givers are supported in giving appropriate information to patients and relatives about the sedation procedure and in asking informed consent of the patient and/or the relatives. The protocol also contains a medication advice and gives criteria when to ask the hospital Expert

team for Pain and Palliative Care for advice.
Methods: In March 2007 the protocol for CPS was introduced in Erasmus MC. To evaluate the appropriateness and use of the protocol, the caregivers were asked to return a copy of the used checklist after each procedure CPS.
Results: From March 2007 till October 2008 47 protocols were returned. In each case the patient's current state was described by the doctor and the conditions for CPS were checked. In 91% of the protocols doctors had completed all information and informed consent items, including information about ending the supply of artificial fluids. Nurses completed the tick boxes on communication about mouth care and the farewell procedure in 53% and 46% of cases, respectively. In 60% of the cases the Expert team was asked for advice related to the indication for CPS or to the sedatives to be used.
Conclusion: The Erasmus MC multidisciplinary protocol CPS was used well. In the returned forms, doctors almost fully completed the indication and information items. Nurses' adherence to the protocol was smaller. It seems that doctors dealt according the indications for CPS and seemed to be willing in asking advice. This supports the importance of this protocol in case of CPS.

PE 2.S138

Hope at the end-of-life: Perceptions of Portuguese cancer patients submitted to palliative chemotherapy

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Hope has been considered one of the essential elements in the way of living of people who suffer from cancer. At the end-of-life, dealing with a terminal disease, when a cure is not possible, hope is fundamental to the way cancer patients live the last period of their lives and determinant for quality-of-life.
Aim: The main aim of this study was: To explore the process of hope for cancer patients The objectives were: Understand how hope is perceived; Identify factors that influence hope; identify how hope is expressed.
Methods: The study was based on a qualitative methodology, using "Grounded Theory" , presented and developed by Glaser & Strauss (1967).
To gather the data we used semi-structured interviews. We used a theoretical sampling according the following criteria: aged over 18; undergoing palliative chemotherapy; accepted to participate in the study and agreed to audiotape the interviews. 11 patients were interviewed (6 males, 5 females), aged between 35 and 74 years, with a time of diagnosis of cancer between eight months and three years.
The interviews were transcribed and analyzed, using three levels of coding, according with "Grounded theory" procedures.
Results: The process of hope was made up by four themes: The perception of hope as inner force, faith, resisting to be able to achieve objectives and hope objects; Perception of the temporal dimension- time t look towards the future, considered the cycle of life; Experiences of hope, characterized by thoughts, behaviors, emotions and relationships lived during the process; and Maintaining hope meaning living one day- at the- time, feeling death as a present limit. Patients identified factors that enhance hope and also hope inhibiters.
A model of "Process of maintain hope" were design based on data analysis.
Conclusion: The results, not generalized, enable to better understand the way patients maintain hope at end-of-life. Suggests an aproach to improve end-of-life care near death.

PE 2.S139

Hydration and the dying patient: The views of bereaved relatives

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Aim: To explore bereaved relatives views about the way fluids were provided in the last days of life, the appropriateness of the method of delivery and the amount of information they were given about the use of intravenous fluids.
Method: Using an expert panel review, questions were proposed to address issues of hydration at the end-of-life. Cognitive 'think aloud' interviews were conducted with 12 bereaved relatives to ensure that questions were relevant and understandable. These questions formed part of Evaluating Care & Health Outcomes-for the Dying (ECHO-D), a 94 item postal self-completion questionnaire developed to assess bereaved relatives' views about the quality of care for dying patients.
The next-of-kin to 778 patients who had died from cancer in a hospice or hospital during a 21 month period were identified and asked to complete ECHO-D.
Results: Following exclusions (n=53), 255 (35.2%) next-of-kin agreed to participate. Participants reported that fluids were most frequently provided by oral mouth care (51.8%). The use of intravenous fluids was less frequently reported by hospice participants (13.8%) compared with hospital participants (32.2%, p=0.001). More hospice participants responded that the method of providing fluids had been the appropriate way (hospice 71.6%, hospital 54.9%, p=0.004). Discussions about the appropriateness of giving intravenous fluids occurred with similar frequency in both settings (hospice 26.6%, hospital 26.0%). More hospital participants indicated that these types of discussions would have been useful compared with hospice participants (hospice 18.3%, hospital 45.2%, p<0.0001).
Conclusions: In the hospital setting, there appeared to be greater use of intravenous fluids in the last days of life and less satisfaction with the appropriateness of this compared with the hospice. More open discussion about the provision and withdrawal of fluids in both healthcare settings is required to ensure optimal patient comfort.

PE 2.S140

Does the Liverpool Care of the Dying Pathway (LCP) have an impact on the quality of care for dying patients: The views of bereaved relatives?

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Aim: To compare bereaved relatives' views in hospice and hospital settings about the quality of care for dying patients and to explore the effect of the Liverpool Care of the Dying Pathway (LCP), within the hospital, on these perceptions.
Method: Evaluating Care & Health Outcomes-for the Dying (ECHO-D) is a 94 item postal self-completion questionnaire developed to assess bereaved relatives' views about the quality of care for dying patients.
The next-of-kin to 778 patients who had died from cancer in a hospice or hospital during a 21 month period were identified and asked to complete ECHO-D.
All hospice patients (n=275) and 267 / 503 hospital patients had been cared for on the LCP. Four composite scales (CARE, COMMUNICATION, SOCIAL AND ENVIRONMENT) were created based on conceptual similarity using factor analysis techniques. Additionally, 7 composite variables were created based on conceptual similarity. The 'Quality of Dying' (QD) scale represented the summed total of these scales (range 0-100).
Results: Of 725 eligible, 255 (35.2%) next-of-kin agreed to participate. Demographic analysis showed that patients dying in the hospice were more likely to be younger, female and have breast cancer. Patients cared for on the LCP had a mean age of 74.6 years compared with 69.6 years for those who were not. The mean QD score was higher for hospice participants (73.1) as compared with hospital participants (50.4, p<0.0001). The range of scores, however, was wide for both groups reflecting a broad spectrum of perceptions about overall quality of care. Within the hospital, higher QD scores were seen for those cared for on the LCP (mean score 55.3) as compared with those who were not (mean score 44.7, p <0.0001).
Conclusions: Overall, patients being cared for on the LCP were perceived to have had better quality care in the hospital than those who were not, although the level of this care did not reach the hospice standard.

PE 2.S141

Developing competencies for end-of-life care in care homes

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Background: Suboptimal end-of-life care in care homes may result from inadequate training. To measure the end-of-life care provided, core competencies are required which set a minimum standard against which specific roles are defined. To achieve and maintain significant improvements in practice, an in-depth training programme needs to be undertaken and outcomes measured. However, training is complex as palliative care derived from a cancer care model may not be directly transferrable to those dying in a care home.
Aim: To enhance end-of-life care practice in care homes, through the development of a core competency framework, supported by a package of education and training.
Method: This collaborative project involves staff from the hospice going into four individual care homes, to work in partnership with care home staff. Stage 1 will develop a competency framework specific to each care home. Focus groups and interviews will elicit experiences in practice to then inform the development of competency statements. In stage 2, the competencies of care home staff will be assessed using the framework, prior to attending a 5 day education programme. It is anticipated approximately 120 staff will participate. During stage 3, individual's competencies will be reassessed in the clinical setting. As part of this, senior care home staff will be trained to assess competency.
Results: The competency framework will be presented including discussion of methods of data collection. Discussion will focus on how education influences the development of competent practice. An outline for stage 3 will be presented including the process of training required by care home staff to undertake clinical assessments.
Conclusion: It is anticipated that the active participation by care home staff in developing relevant core competencies in end-of-life care will improve the experience for patients.

PE 2.S142

Community based nurse led palliative care clinics

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Aim: The clinics are multicultural, accessible and for patients with a palliative care diagnosis regardless of their disease, whom are either working or remaining independent within their own homes but had no choice of support other than home care yet may benefit from earlier identification and sign posting to other services.
Methods: A mapping of current service provision in 2005, identified gaps in support of these patients. A steering group was formed of key people who were currently providing palliative care plus service users. An operating policy was agreed and the clinics were commenced as a six month pilot. Patients are referred from clinicans working in cancer and other diseases at time of palliative diagnosis for an holistic assessment of their needs by a specialist palliative care nurse. A new patient appointment is an hour and follow ups are 30 mins. Following a clinic visit, a communication proforma is completed and faxed to the referrer and Primary health care team raising awareness of patients needs.
Results: A patient satisfaction questionaire was designed and patients stated that they found the clinic offered choice and addressed their needs earlier in their disease. Since the start of the clinics in 2006, over 250 new patients have accessed the service with over 600 follow up appointments. Clinics are now held Monday to Friday in various community locations. Patients re refer themselves as any new problems arise. As their disease progresses and they are no longer able to attend a clinic, home support is then given via the district nurses working in partnership with the aligned specialist palliative care nurse.
Conclusions: The Department of Health End of Life Care Pathway (2008) is underpinned by support and information for patients and carers. The clinics enable earlier interventions and ongoing support thereby ensuring patients choices and preferences are met and they are more likely to die in their preferred place of care.

PE 2.S143

Living on hold

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Today, more and more people die in their own home, which fundamentally affects the home care. The aim of this study was to develop a classic grounded theory of palliative cancer patients and their relatives receiving palliative home care. We analyzed interviews and data related to the behavior of both patients and relatives. "Living on hold" emerged as the pattern of behavior through which the patients and relatives deal with their main concern, being put on hold. This involves a break down of normality and much time spent waiting. Often, this leads to feelings of powerlessness, decreased freedom and loneliness. The theory Living on Hold involves three modes; Fighting, Adjusting and Surrendering. In the Fighting mode patients and relatives refuse to be put on hold and are striving to renormalize their lives. In the Adjusting mode they are adjusting to a life on hold creating a new normality and new routines. In the Surrendering mode they are releasing control of normality and surrender to a life on hold in the hands of others. Mode being may change during a trajectory and actual mode being depends on many factors such as age, personality, type of cancer diagnosis and prognosis, social network, earlier experience of crisis, competence of health professionals, and continuity of care. There are also different triggers that can start a reconciling/re-evaluating process leading to a change of mode. This means that patients and relatives can either be in the same mode or in different modes simultaneously. More or less synchronous modes may lead to problems and conflicts within the family, or with the health professionals. For example, health professionals that gives anticipatory care clash with persons in the Adjusting mode but goes well with persons in the Fighting and Surrendering modes. It is therefore important for the health professionals to be aware of what mode/modes the patient and the relatives are in, to be able to meet and communicate at the right levels.

PE 2.S144

Raising the Bar in generalist palliative care

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Aim: Raising the Bar was developed from a piece of work to standardise care given by generalist palliative care providers to ensure best supportive care to all palliative patients regardless of their disease.
Methods: A six month District Nurse audit was undertaken which showed disparity in the number of palliative care patients and place of death on individual district nurses caseloads. A working group was formed which comprised of specialist palliative care providers and district nurses who agreed core minimum standards of care and support that nursing teams were expected to deliver. A generalist palliative care pathway was created which supports the patient and families throughout their illness. The responsibilities of generalist and specialist palliative care roles were clarified. A criteria was agreed for Red, Amber and Green status of patients to aid communication between teams. Individual team response was also identified for each level.
Results: Gaps in the district nurses capacity have been identified and funding has been secured for extra staff to provide the agreed pathway and the extra training required to do this. The process is now being rolled out across all care settings. An audit of this programme will feed into end of life care monitoring.
Conclusion: The Department of Heath End of Life Care Pathway (2008) is underpinned by support and information for patients and carers. This generalist pathway ensures consistency and high standards of care and helps improve the patient and carers experience and supports the local Primary Care Trust to increase the number of home deaths.

PE 2.S145

Empirical insights into spiritual care for the dying

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Background: Spiritual Care within Hospice and Palliative Care is usually assigned to pastoral care services. There is, however, a lack of empirical data describing what pastoral care actually does. Health care providers and religious institutions need realistic data in order to plan, organize and fund spiritual and pastoral care services.
Methods: Chaplains serving on 8 German palliative care wards and hospices documented every task performed during 30 consecutive days using a one-page form. Questions included clinical status of the patient, who initiated the intervention and what was the indication. Pastoral care services were divided in two basic categories:
a) guidance and counselling (e.g. exploration of situation, biography or matters of belief, crisis intervention, counselling in ethical conflicts, interdisciplinary case discussions)
b) liturgical and ritual acts (e.g. prayer, blessing, anointment, farewell rites, eucharist). Additional data was collected on the time spent in regular team meetings, conferences, supervision and religious services (e.g. memorial services).
Results: 250 forms were returned. The mean length of contact was 36 min (range 25-52 min). 60% of contacts were with the patient alone (32% with patient and family member, 8% only family). 13% of patients were in acutely life-threatening conditions, while 13% were described as dying (15%). 8% of visits took place after the patient's death. 55% of the contacts included ritual acts. Counseling was requested only by patients with a Christian background, but not by members of another or no religious tradition. The data indicate a minimum requirement for spiritual care of one hour/patient/week.
Summary: Our data give insights into the actual performance of spiritual care by the pastoral care staff, including required time and different forms of intervention. Although the regional population is mostly Roman catholic, pastoral care services were also used by members of other or no religious tradition.

PE 2.S146

Oxycodon Slow Release (S.R.) + Zonisamide for cancer pain: A randomized, single-blind, controlled pilot-study

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Aim: Whereas the estimade made by Surveys, 40-50% of cancer patients suffer from neuropatic pain, is useful and frequent antiepileptic subministration like adiuvant in the cancer pain treatment in a politherapy with opioids.Subministration of Zonisamide and Oxycodon S.R. in management of cancer pain wasn´t investigated still. This study end-point was improvement in pain.
Methods: The study was carried out in the San Giuliano hospital, Giugliano, Naples, Italy, starting in october 2007 and lasting until october 2008. Pain intensity was assessed using NPS score. Patients were checked through weekly follow ups for 8 weeks, at every follow up we learnt vas score and the undesired effects. The exclusion criteria were: vas< 4,0, contraindication to sulfonamides, opioids.
Statistical analisys was performed by T-test.
Results: 32 patients received the study drugs like prescribed. mean age 68,4 male 21. T0 mean vas: 7,6 s.d. = 1,93 T0 Mean dosage zonisamide =65,4 mg s.d=42,4 T0 mean dosage Oxycodon S.R. =52,6 mg s.d. = 23,1. mean vas reduced more 50% of mean vas T0 since T28. Mean daily dosage zonisamide was under 150 mg for all the study (range 50-200mg). T28mean vas=2,9; T28 mean vas=2,37.

	T0	T14	T28	T42	T56	T70
vas Mean	7,6	4,1	2,9	1,97	2,32	2,21
vas s.d.	1,93	2,77	2,37	1,23	1,54	1,76
zonisamide Dosage mean	65,4	71,5	83,7	106,25	113,5	100,5
zonisamide Dosage s.d.	42,4	38,8	49,5	47,5	58,6	53,2
oxycodon S.R. Dosage mean	52,6	58,3	64,7	77,1	72,8	75,2
oxycodon S.R. Dosage s.d.	23,1	22,6	28,9	31,3	28,6	20,2

T-test: Differences between T0 vas values and vas value of every follow up are explained by casual fluctuations with difficulty (improbably).
Conclusions: Oxycodon S.R. + Zonisamide in treatment of cancer pain wasn´t studied yet, this pilot-study shows that the administration of these drugs in combination is useful in the control of cancer pain, with mild and transient side effects, good compliance and low dosages of both drugs.

PE 2.S147

An experience of Buddhism based palliative care 2: How Buddhism priest see their roles in PCU?

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Introduction: One of the important aspects of Palliative Care must be the issue related to religional /spiritual domain. It is well-known that the original concepts of the Hospice Movement which has been developed into and flourished as "Palliative care" was under the influence of Christianity. However not all countries have affinity with Christianity. Vihara was established as a care facility for dying based the Buddhism in 1992. "Vihara"means" The rest place, or stroll for leisure (diversion) " in Sanskrit.
Objective: It aims to analyze how the religion in Japan is functioning and What is the role of Bonze (Buddhism priest) in the palliative care unit based Buddhism, especially in the points of a spiritual pain.
Method: Three Focus group was organized from the member of The Association of Buddhist Vihara, which has been working as the voluntary group to help Vihara for the daily sertvices and some other seasonal ceremony. Each group consisted of 3 to 4 people who willing to paticipate the research, and have a talk with a facilitator in a secure and private room. Semi-structured Topics (motive, evaluation, and commitment) were produced by the facilitator. In Adidtion, private semi-structured interview was also performed for several people.
Result and discussion: 11 people participate the Focus group in April 2008,and 7 people were interviewed in June 2008. All conversation was recorded and transcripted.
As for the answer of the Buddhism priest who was related to the vihara ward, the difference was seen by years that were actually related.
It seems that the difference between generations is related to religious circumstances of present age in Japan. Especially, it might be hoped that the religionist doesn´t push the religion (Buddhism) out forward but attaches importance to relations between the person and the person, and puts out the essence of the religion in recently.

PE 2.S148

Request to turn off life sustaining Left Ventricular Assist Device

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The use of Left Ventricular Assist Device (LVAD) is increasing in patients with congestive heart failure (CHF). Approximately 1000 LVAD´s are placed in the United States of America per year. In the Randomized Evaluation of Mechanical Assistance for the Treatment of Congestive Heart Failure (REMATCH) trial 129 patients were randomly assigned to LVAD or optimal medical therapy. Results showed higher survival in the LVAD arm. One year survival for the LVAD arm was 52%

versus 25% for those optimized medically.
Mr A, a 64 year old male patient, had a paracorporeal LVAD placed for idiopathic CHF in July 2007 as destination therapy with the possibility of bridge therapy to transplant. He was admitted to the hospital in August 2008 with worsening CHF which responded well to the addition of a dobutamine drip for ionotropic support. Patient reported progressive and severe fatigue and dyspnea not responding to opioids resulting in unacceptable quality of life, and subsequently requested that the LVAD support be discontinued. One of the nurses caring for the patient had religious objections and was allowed to refrain from participating. The patient expressed a fear of feeling suffocated, and requested that he not be aware when the device was turned off. At a time determined by the patient, he was placed on a midazolam drip, titrated up to 12 mg an hour intravenously to ensure sedation. Once sedated, the implantable cardioverter defibrillator was turned off. Per family´s request, prayers were conducted at bedside by the patient´s physician. Subsequently the dobutamine drip and the LVAD were turned off. The patient died peacefully within a minute. His family was at the bedside per his request.
As the use of LVAD increases, palliative care professionals need to familiarize themselves with the end of life issues related to the intervention. Quality of life issues should be re-evaluated on a regular basis and the option of turning off the device should be presented when placed.

PE 2.S149

A national guideline for spiritual care in the Netherlands

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Aim: In the Netherlands palliative care is organised by eight comprehensive cancer centres (CCC's) the aim of which is to provide cancer patients and their families access to comprehensive and high-quality care as close to home as possible. In January 2006 the CCC´s published a book comprising 31 guidelines covering the physical and psychosocial dimension of palliative care, including a psychological guideline on ´existenial crisis´. Still lacking was a guideline for spiritual care. The aim of this project was to write a national guideline for spiritual care that is recognised as a useful tool for physicians and nurses from different spiritual and or religious backgrounds.
Methods: In 2006 a small working group was installed by Agora, the national platform of national palliative terminal care. The working group consisted of people form different spiritual backgrounds that play an important role in the Netherlands. During two years more than 10 meetings were held in order to develop the guideline. After one year the board of the book of the CCC guidlines suggested that the guideline for spiritual care should contain a revised version of the already exisiting guidline ´existential crisis´. After completion of the guidline the text was send out in various rounds to various health care professionals of different professional backgrounds throughout the country.
Results: The guideline for spiritual care is ready now and will be launched in the beginning of 2009. It consists of a three layer approach distinguishing between
(a) general attention to spiritual matters,
(b) support during difficult spiritual processes
(c) special interventions in spiritual crises.
Conclusion: A national guidline for spiritual care is an important tool for strenghtening the spiritual dimension of palliative care. Although a hard job to develop such a guideline, it is possible to develop it at the evidence level of expert opinion.

PE 2.S150

The implementation of the Liverpool Care Pathway, LCP, in Swedish care homes

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Aim: To increase the quality of palliative care in care homes using the LCP as a tool for education and support in care of the dying patient.
Background: Good care of the dying should be seen as the norm and not the exception in our society. The LCP is a tool used to transfer the hospice model of care of the dying into other care settings. With the increasing number of deaths in care homes considerable internal challenges need to be met.
Method: Six nursing homes in Stockholm participated in the project. An education programme based on the LCP goals was given to all staff. Further teaching was provided within specific areas in palliative care and expressed needs identified from the staff. Evaluation of documentation was carried out before and with the LCP. The project will also be independently evaluated.
Results: Experience from the implementation process will be reported. This includes strongly expressed needs from staff for guidelines, education and support. Challenges include low staffing levels, lack of knowledge and competence in palliative care, resistance to change, and availability of drugs for symptom control. Lack of physician support and expertise are important factors as well as communication problems due to lack of confidence, differences in attitudes and beliefs about death and dying and hospitalisation of dying residents.
Discussion: The implementation of the LCP can increase confidence and competence in caring for the dying but also change attitudes, knowledge and skills affecting the care of patients at an earlier stage of disease.

PE 2.S151

Is what we document the same as what we do? Interviewing professional caregivers to analyze current end of life-care practice in a general medical inpatient department

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Aim: In an academic general medical inpatient unit with a high death rate, a structured protocol for end of life-care is being implemented, the "Liverpool Care Pathway" (LCP). Reviews of recently deceased patients' charts, which are evaluated by a central reference institution, are conducted at baseline and after implementation of the LCP to document any changes in care. To adopt this process to the local environment and to assess awareness about end of life-issues, a more subjective approach is needed. Therefore, we decided to supplement the base review (quantitative methodology) with qualitative interviews of the involved medical and nursing staff.
Methods: Qualitative, semi-structured interviews about the perception of current end of life-care practice. Mixed-method comparison of self-perception (interviews) to LCP base review (chart reviews).
Results: Preliminary analysis of the interviews (n=16) demonstrates that professionals are familiar with standard palliative procedures. However, marked differences of nurses' and physicians' attitudes exist regarding the diagnosis and onset of the dying process. While nurses tend to advocate restriction to symptom-oriented therapies only earlier in the course of illness, doctors are more reluctant to label a patient "dying", and are more willing to provide specific disease-modifying interventions. Quantitative base review revealed that 40% of patients and relatives were unaware of the dying process; communication/information issues are often not documented.
Conclusion: In an inpatient unit where dying is common, caregivers are comfortable with delivering care to the dying. In contrast, views on what constitutes "dying" diverge widely, possibly resulting in a reluctance to communicate openly and timely with dying patients and their families. Specific education may be needed to bridge this gap. Final data will be presented at the EAPC meeting.

PE 2.S152

Oral health in advanced cancer - A neglected problem? Results from a dentist's examination

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Aims: Up to 70% of cancer patients experience oral problems during the disease trajectory, especially in late stages of the disease. Few quality of life (QoL) or symptom checklists include items on oral health. Oral care interventions are seldom documented in the medical charts. In the present study, an oral examination was performed by a dentist to study the prevalence of dental and oral problems in palliative care (PC) patients.
Methods: This descriptive study recruited 126 cancer patients with advanced disease from two Norwegian PC units. Patients were interviewed, completed the Edmonton Symptom Assessment Scale (ESAS) and underwent a clinical oral examination.
Results: Ninety-nine patients (79%) agreed to participate; 47% males, median age 65 (36-90), median Karnofsky score: 40 (20-80), 73% with a life expectancy of <3 months. Gastro-intestinal (31%) and lung cancer (19%) were most prevalent. The majority (87%) had metastatic disease. Highest ESAS mean scores were: 4.9; tiredness, 4.7; xerostomia and 4.4; poor appetite. Xerostomia was reported by 78% and 70% showed mirror test friction. Clinical oral candidiasis was seen in 32%, 69% grew more than 9 colonies from mouth swabs on Sabouraud's agar. Moderate or rich amounts of dental plaque were seen in 24%, mean number of diseased teeth was 1.9. One patient had bisphosphonate-associated osteonecrosis of the maxilla. Few patients used dental prostheses (14%). Mouth pain was reported by 67% and 56% reported problems with food intake. Overall, 77% said they had received no information about oral side effects of cancer treatment.
Conclusion: In a PC population, an oral and dental examination supplemented by specific questions revealed a high prevalence of problems. Despite the negative impact on functions, nutritional status and QoL, oral status is not routinely assessed and oral care protocols seldom exist. Increased awareness and assessment of oral problems are necessary for improved management and information.

PE 2.S154

End-of-life research on patients´ attitudes in Germany: A feasibility study

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Aims: Studying end-of-life issues in palliative care patients in Germany is still seen with a lot of scepticism. This study reports a) how patients and relatives reacted to a study protocol introducing the topic of attitudes towards hastened death within the first days of admission to a palliative care unit, and b) why patients could not be included into the study.
Methods: Within a protocol for validation of the German version of the SAHD, patients on palliative care units in Aachen, Bonn and Cologne were screened for inclusion by the treating physician, and were finally included into the study by the researcher. Reasons for non-consideration and non-inclusion were documented and analysed.
Results: Of 124 patients seen, 65 (52%) were not considered fit for inclusion due to physical disability (n=35, 54%), cognitive impairment (n=21, 32%), psychological distress (n=19, 30%), communication problems (n=15, 23%), and imminently dying patients (n=17, 26%).
Of the remaining 59 patients, 41 patients also could not be interviewed due to refusal to participate (8), rapid deterioration of physical status (11), psychological distress / need for psychological intervention (5), imminent death (4), cognitive impairments (2), and others causes (9) (multiple answers possible).
Altogether, only 18 interviews (15 %) were performed. On average, 3.8 contacts were required (range 1-14) to establish whether the patient could be included in the study or not. These patients reported that the experience of the study was very positive to them.
Conclusion: Reasons for non-inclusion were mainly due to the clinical status of the patients. We conclude that end-of-life research in Germany is indeed feasible, but meets recruitment difficulties similar to the international experience.
This study was funded by the German Research Foundation (VO 497/4-1).

PE 2.S155

'Going for gold'

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Aims:
1. To maintain consistency and sustainability of practice of end of life care in care homes through a development of a rigorous accreditation on process for care homes (nursing) having completed the Gold Standards Framework for Care Homes Training Programme.
2. To develop a national community of learning in sharing worked examples of good practice and creative initiatives in end of life care in care homes.
3. To provide a means of Quality Improvement, Quality Assurance and Quality Recognition for care homes providing end of life care.
Methods:
• Development of accreditation process in line with objective internationally recognised accreditation procedures
• Invitation to care homes in Phase 1-3 who have completed GSFCH training programme
• Development of accreditation assessment methods ie checklist, online After Death Analysis, portfolio and independent assessment visit
• Objective panel and criteria for pass, commend and beacon awards developed
• Feedback from all contributors and care homes involved to Help the Aged and Central Team supporter.
Results: The GSFCH 'Going for Gold' Accreditation process was developed and well evaluated - 42 homes registered for accreditation, 34 passed, 8 deferred. Of the 34, 5 were Beacon, 8 Commended, 21 passed.
An Award Ceremony was held with presentation of plaque.
Feedback report was produced and recommendations integrated for Round 2.
Showcased examples of good practice shared with others, staff filmed and DVDs used in training.
Conclusion: This was a successful pilot accreditation process and is now fully integrated in the GSFCH Training Programme.
Further Rounds of GSFCH Accreditation are already booked and registrations received Benefit of accreditation being built upon, much media interest and recognition of good practice in care homes.
Funding: Self funded through the National GSF Centre, (Walsall tPCT) and care homes. Initial Accreditation Process developed with a grant from AWM.

PE 2.S156

Defining personal dignity at the end-of-life: Views from patients and experts

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Background: Maintaining dignity is recognized as an aim of palliative care. Dictionaries define dignity as the quality of being worthy of esteem or respect. However, there is lack of clarity on the definition of dignity and on the relation between the concepts of dignity and quality of life in empirical research on dignity.
Aims: Investigating views of patients and experts on important elements of the definition of dignity and experts' view on the relation between dignity and quality of life
Methods: Quantitative framework of this study is the cohort of people with an advance directive. In the second measurement round (n=5477, spring of 2007) the written questionnaire included the open-ended question 'Can you define dignity?' for a (random) half of the cohort. Answers of respondents who had an illness (n=1192) were analysed. These results, and results from a literature search, were discussed in an expert meeting including physicians (n=4) and ethicists (n=3).
Results: Patients often define dignity in a negative way: they use situations that would hamper their sense of dignity in defining dignity, such as becoming dependent on others for care or loosing mental capacities. Important elements of the definition of dignity were both being able respect ones self and being respected or taken serious by others. The experts did acknowledge an important overlap between dignity and quality of life, but considered that the concept of dignity added a sense of urgency; having access to internet e.g. might improve ones quality of life, but probably does not hamper ones sense of dignity.
Conclusions: Dignity can be distinguished from quality of life. The experts suggested that in studying sense of dignity, respondents' own idea of what constitutes dignity for them, is at least as important as having one general definition of the concept.

PE 2.S157

Removing barriers to usage of liverpool care pathway in acute hospital - A multi-disciplinary approach

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Background: The Liverpool Care Pathway (LCP)is currently recognised nationally and internationally as a useful tool in end of life care. Patients are being identified as dying by teams but there remains reluctance to use the Liverpool pathway despite clear decision making around do not resuscitate cardio-pulmonary resuscitation being made. The Liverpool Care Pathway is audited nationally and a summary of the last audit highlighted that our trust had a LCP usage of 23% for the year.
Method: A base line review this year of hospital deaths within our trust identified usage of Liverpool Care Pathway in 15.8% of patients. A repeat retrospective audit of all patient deaths over a three week period highlighted that a significant number identified as actively dying in the case notes in the 48 hours prior to death had their DNA-CPR status recorded but no use of LCP. A confidential questionnaire was sent to staff on 10 wards asking views as to the perceived barriers to implementing the LCP when it was felt that death was imminent.
Results:
• 58% suggesting that senior doctors attitudes are an obstacle for implementing the LCP.
• 23% identified the diagnosis of dying
• 10% highlighted a lack of knowledge of use
• 8% other reasons.
Conclusion: We have incorporated a prompt" Is the patient dying, consider using the LCP" onto our DNA-CPR record to empower teams to address these barriers. Further research is required to identify if this prompt enables higher usage.

PE 2.S158

De-tabooing - A grounded theory of end-of-life control

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Since the 1960s open awareness of dying have started a de-tabooing of end-of-life control (EOLC) in the western world going in two directions with palliative care being reversible and euthanasia/assisted suicide (EAS) and termination of life support irreversible EOLC.
We analyzed public and physician opinions about EAS in a mail survey to a random population and physician sample in Sweden 2007. Population response rates were 695/1200 (58%) and 890/1200 (74%) among physicians. We analyzed open-ended responses of 6500 words, data from 48 interviews with people from Sweden, Denmark, the UK and USA, four different Internet message forums, and literature using classic grounded theory procedures (Glaser).
Within the de-tabooing of EOLC we can see a juggle between an old taboo of controlling death and a recent anathema of disrespecting autonomy. This taboo juggle explains the current attitude climate in the western world with an obvious de-tabooing in the BeNeLux countries and Oregon as seen in their EAS legalisation. Taboo juggling may start with an instant emotional reaction to EOLC. Then a definition confusion about the type of EOLC being discussed, ie EAS or termination of life sustaining treatment, or palliative sedation. Then a reflection phase of arguing pro and con by exampling, comparing, and by conditioning EAS. EAS proponents can be "hyperautonomists" with body ownership arguments, "conditioners" emphasizing safety and legal criteria, and situational accepters of EAS. EAS opponents may be socionomy defenders, role defenders or risk-avoiders. De-tabooing counter arguments are: abuse risk, conditional slipping, procedural failures, needless if palliative care / palliative sedation offered, and professional role erosion.
We thus suggest that de-tabooing of EOLC in the western world explains both the growth of palliative care and EAS legalisation in the BeNeLux countries and Oregon. A taboo juggle between controlling death and disrespecting autonomy also emerges.

PE 2.S159

Evaluating thromboprophylaxis on a palliative care unit

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Background: Patients may be admitted to our 36-bed Palliative Care Unit (PCU) from acute medical and surgical units on therapeutic or prophylactic anticoagulation (AC). Our group previously conducted a retrospective study of the use of low-molecular-weight Heparin (LMWH) on our PCU. This and a prospective audit of decisions upon admission regarding LMWH prompted development of an algorithm to guide anticoagulant use on the PCU.
Algorithm: AC is discontinued in patients with ≤ six months life expectancy unless treatment is for thromboembolic disease (TED) within last six months, when decision to continue or discontinue is individualized. No prophylactic AC is initiated for patients on the unit. The algorithm allows AC with LMWH in patients with symptomatic TED if the patient consents.
Goals: A prospective audit is underway to document the use of AC, including LMWH, as a result of implementation of the algorithm. Deviations will be explored to assess if the guidelines need revision. Data collected over six months will be compared to results of our previous audits to evaluate the impact of the algorithm. The results of the study will be presented.
PS: Prophylactic treatment may be considered in patients with temporary immobilization resulting from chemotherapy treatment or surgery (e.g. pinning of fracture).

PE 2.S160

Costs of service provision over the palliative care trajectory

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Introduction: There has been a dramatic shift in the provision of palliative care from hospitals to in-home care. The characterization and magnitude of this change in the site of delivery in terms of resource costs remain unknown. This study measured direct costs associated with home-based palliative care, and specifically, visits by physicians, nurses, and personal support workers as well as ambulatory resource costs.
Methods: Study participants were recruited from the Temmy Latner Center for Palliative Care (TLCPC), a regional palliative care program based in Toronto, Canada. One hundred and thirty-six palliative patients and their family caregivers participated in the study. Information regarding service use was obtained through structured telephone interviews with family caregivers.
Results: The mean total direct cost of care per patient for ambulatory and home-based services was $ 5,055 per month (2006 CDN). The largest component of these costs (74%) was comprised of services provided by personal support workers (mean monthly cost =$2,941 (2006 CDN)). The mean monthly cost of nursing visits was $605 (2006 CDN). Ambulatory services, which consisted of lab and diagnostic tests, hospital admissions, emergency room visits, and physician services comprised 6% of total direct monthly costs ($243 (2006, CDN)). Physician home visits made up the smallest cost component (3%) with $125 month (2006 CDN). Variation in the proportion of each direct cost component over the palliative care trajectory was also assessed. The findings may provide insight into resource allocation planning within home-based health care organizations. Specifically, fiscal restrain warrants consideration of program costs (and outcomes) in order to inform resource allocation decisions that advance the efficient, effective and equitable distribution of health care resources.
Funded by CIHR/CHSRF Health Services Chair.

PE 2.S161

Psychological and psychosocial support for cancer patients in their last days of life - A literature review

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Aim: Psychological and psychosocial support (PPS) for cancer patients is consistently reported in literature as an essential part of palliative care, able to ameliorate the prognosis of patients and increase substantially their quality of life. Despite of these data, much less is known about the scope and utility of PPS for cancer patients in their last days of life, therefore the main objective of this study, realized on behalf of OPCARE9 European collaboration, was to evaluate the number and content of articles published so far about PPS care dedicated specifically to terminal patients.
Methods: Experts in the field of palliative care from Romania and Germany were asked to define PPS care for terminal patients in their last days of life. Keywords provided were used in a search string to identify articles relevant to the theme. Databases analyzed were PsychINFO and Medline.
Results: 33 German and 25 Romanian experts responded (average response rate = 64%), with sample comprising physicians(inclusive GPs), psychiatrists, psychologists, social workers, nurses, chaplains and hospice workers. Following keywords provided by them, 120 hits were identified, showing a diverse array of topics, such as adequacy of care, PPS needs, applicability of theoretical models and quality of life. However, only 8 articles focused on the specific target of the literature review.
Conclusion: An extended Delphi round of experts could provide supplementary keywords, which can lead in the next step to a refined search strategy and identification of other studies dedicated to this topic. So far, presented data suggest that there is still a poor coverage of the theme in the present-day literature and further research is to be undertaken in this field.
This study was funded by the EU 7th Framework.

PE 2.S162

Delivering end of life care in the prison setting - Adaptation and implementation of the Liverpool Care Pathway for the dying patient (LCP)

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Background: England and Wales have the highest number of life sentenced prisoners in Europe and the number of prisoners aged over 60 has risen 185% in ten years. Our local prison healthcare unit (the only one of its kind in Europe) provides care for older life sentenced prisoners. Patients are often admitted with significant palliative care needs due to a life limiting illness from which they subsequently die.
As part of our specialist palliative care outreach service, we have introduced the LCP within the prison unit. The LCP is a continuous quality improvement framework for care of the dying - to our knowledge there has been no published work looking at its use within prisons.
Content: The paper describes our experience using the LCP within the prison setting and for prisoners dying in other local healthcare settings. We have worked closely with prison colleagues to adapt the LCP specifically for use in this setting and are now piloting it.
The areas needing special consideration within the prison setting are discussed:
- Security issues - commencing a patient on the LCP triggers a review of the prisoner's security status, allowing significant issues to be addressed (including relatives being given access and the cell door being left open, allowing nurses 24 hour free access).
- Resuscitation - clear processes are in place to ensure the patient's resuscitation status is addressed at an early stage.
- Piloting the LCP within the prison has highlighted the need for easily accessible educational resources.
- Joint working between the specialist palliative care service and the prison service has led to changes in the procedures following death.
Conclusions: The LCP is designed to transfer best practice for care of the dying in the hospice environment into other care settings. This work describes its use in one of the most challenging healthcare settings and has been highlighted as good practice within the 2008 End of Life Care Strategy for England and Wales.

PE 2.S163

The alternation of need and satisfaction of health care of terminal patients Kaunas University of Medicine

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End of life
Goals: To analyse the alternation of physical, psychological and spirituality needs of terminal patients.
Aim: To evaluate the alternation of need and satisfaction of health care of terminal patiens.
Methods: The research was performed in the way of questionanire based of literature.
The results: It was set, that the main physical symptoms of the patients, who took examination before they died were: pain, poor appetite duering eating and dyspnoe. The main psychological problems to patients were: taciturnity, anxiety and depression. The most important spirituality problems were the loosesess of essential life point and permanently tiring thoughts about death.
Evaluating the satisfaction of health care of the patients who took examination before they died it was set that pateints moslty were dissatisfy of their health, opportunity to live as long as they want, abillity to take care by them selfs and changes of life, becauce of illness. the main reasons of dissatisfy in alive pateints life was changes in their life because of illness, ability to carry responsibility and opportunity to live as long as they want.

PE 2.S165

Self-assessment of knowledge, attitudes and skills on end-of-life care of medical residents in a private tertiary hospital

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Introduction: Most medical residents feel uncomfortable with providing terminal care and discussing advance directives with dying patients and their families. The Palliative Care Unit of the Cancer Center was recently established and the medical residents are only beginning to get exposed to palliative care principles and concepts as some of them go on rounds and have case management meetings with palliative care specialists.
Aim of investigation: To determine the effectiveness of mentoring by palliative care specialists in changing medical residents' attitudes, knowledge and skills toward end of life care and quality of death in patients.
Methods: Questionnaires are administered to medical residents incorporating self-assessment of knowledge, attitudes and skills toward end-of-life care and quality of death of their patients. Analyses would compare responses of residents who had a hand in managing patients of palliative care specialists and those who did not.
Results: In general, those residents who were exposed to palliative care principles and concepts during ward rounds and case management meetings with palliative care specialists had better scores in their self-assessment of knowledge, attitudes and skills toward end-of-life care and quality of death of their patients.
Conclusions: Ward rounds and case management meetings with palliative care specialists may be an effective model for training medical residents on end-of-life care and quality of death of terminally-ill patients.

PE 2.S166

Palliative care for patients in a university hospital - The nurses' standpoints

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Aim: Although palliative medicine is an emerging new discipline, the dying patient still feels sometimes lost in hospitals which provide emergency and high-tech medicine. One of the many reasons for it might be the missing communication strategies between the different team members working with the dying. Each member of the team caring for terminally ill patients has his/her own thoughts and needs. Therefore, caring for the dying challenges the complexities of the entire team. Interactions and the mutual support are the basics for an optimal management of these patients.
Materials and methods: Nurses on various wards of our university hospital were provided with a standardised questionary. The main points were the needs for palliative care nursing, the communication between the various team members (e.g. physicians, nurses, social workers, chaplains) and the expectations for a specialised "palliative care nurse".
Results: From the 182 distributed questionaries 87 have been returned so far (= 48%). The most important finding has been that the main burden (important conversations with the patient and the relatives) is taken by the nurses. The nurses working at the different wards had very similar feelings regarding the physicians dealing with death and the dying. Often it has been reported that there was a lack of communication between the physician and the patient but also between the physician and the nurses. Importantly, the nurses' stuff tries to support the team members caring for dying patients, but could need some more conversation within and with other teams.
Conclusion:
1. Nurses are working close to the dying patient and the relatives and are sometimes emotionally overhelmed by the situation.
2. There is a strong need to enhance communication between the various persons/ teams working with dying patients.
3. Normally, in every hospital are resources and possibilities which should be used to support the team working with the dying.

PE 2.S167

An exploration of the use of a sensory room as a therapeutic environment in providing holistic care for people with palliative care needs

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This poster presents an initial exploration of developing a sensory room as a therapeutic environment in a specialist palliative unit. Patients and their carers use the room for receiving massage, aromatherapy and reflexology. The room is furnished with equipment which appeals to sight, hearing, touch and olfactory functioning. Items for tasting can also be provided. Whilst the literature addresses the use of sensory environments for client groups with dementia or learning difficulties, there is comparatively little written about using such facilities for people requiring palliative care.
 It is suggested that, due to the nature of some treatments and health care environments, people may have had unpleasant sensory experiences. In seeking to achieve active and holistic palliative care it is suggested the nature of the environment may have great significance.
The sensory room has been developed with the intention of providing a therapeutic environment in which people can use individually tailored sensory experiences. The aim is to offer users the opportunity to enhance their sense of relaxation and well-being, to explore coping mechanisms and to connect with their inner selves in creative ways. It may also be a means by which individuals can divert their mind and energy, occupying not just a different space but a different way of being.
Information regarding the experiences and observations of those people using the room will be collected and analysed to reveal the nature of common themes. Data which reflects the experiences and evaluations of patients, carers and therapists will be triangulated in order to gain a comprehensive view. Evaluation will be used to inform and develop the use of the room.
The study will explore how a sensory room can provide the opportunity for people to enjoy experiences which appeal to all five senses in a therapeutic environment, and how this may enhance or, indeed diminish, physical, psychological, social and spiritual well-being.

PE 2.S168

Complementary therapies in german hospices - An exploratory study of current practices

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Aim: Complementary therapies are widely spread in end-of-life care (Cotton 1999) and though most of them are lacking scientific evidence users are reporting a variety of positive physical, psychosocial and spiritual

effects. This paper focuses on the dispersal, reasons and benefits of the use of complementary therapies in hospice care in Germany and is based on a larger ongoing study on effectivity of complementary therapies in palliative care.
Methods: For this exploratory study qualitative interviews (n=10) were conducted to gain a deeper understanding of current practices with these therapies in hospices. The sample included hospice managers and complementary therapists in seven different inpatient hospices in Germany. All interviews were tape-recorded, transcribed verbatim and analysed using grounded theory methods.
Results: A huge variety of different complementary therapies are applied in the included hospices with aromatherapy, reflexology, wet-packs, Shiatsu, Craniosacral Osteopathy, art and music therapy among them. Nurses take a leading role in applying complementary therapies but in no case they were challenging conventional medicine. Especially in symptom therapy complementary therapies are supposed to improve quality at the end of life. Furthermore these applications are seen as supportive to professionals as well as patients` relatives by intensifying relationships to the dying people particulary through touch and body-work.
Conclusion: The concept of palliative care, which addresses mind, body and spirit seems to legitimize health professionals, especially nurses in hospices, to apply complementary modalities to enhance end-of-life care. Though there is also a strong conceptual emphasis on interdisciplinary teamwork in hospice care, complementary therapies do not seem to be part of that. Further research is needed to uncover the different facets and prospects of complementary therapies in end-of-life care.

PE 2.S169

An expirience of Buddhism based palliative care 3: Reconsisering the social consiousness of relegion

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Introduction: Japanese hospices have been influenced by Christianity, but it seems that it doesn't match for Japanese consciousness for death and religion.
Then, we would like reconsider the social consciousness for death and religion among Japanese people through the research people related to Nagaoka west hospital (vihara ward).
Objective: It aims to analyze how the religious activity on Vihara ward influences among nurses, patients and Buddhism priests themselves. Through it, we describe not only the meaning of Vihara movement, also the consciousness of death and religion in Japan.
Method: We have been researching the Buddhism priests and nurses related to the Vihara ward since May,2008. Semi-structured Topics(caring, death, and religion) were produced. The total amount of interviewee is 30 persons. More, we plan to research for the survivor of patients in Vihara. Through these we try to find out the relationship of caring between priests, nurses, and families and analyze the complex of religious consciousness among them.
Result and discussion: At first, we find that almost all of the patients and nurses don't have the religious viewpoint for caring and death, but it seems that there are implicit consciousness for respecting Buddhism. Secondly, priests don't want to push their religion against nurses and patients. Instead, they would like to tell the patients some dairy episode and event that contain the religious meaning. Through them, it seems that patients accept religious meaning of death indirectly.
Finally, we suggest the social policy that might be suitable for Japanese conditions. Needless to say, Japanese people feel strange for Christianity. However, they also feel discomfort for strict Buddhism. Then, nurses and priests care for the patients without using religious meaning directly. We insist that social policy must consider such a complex, implicit social consciousness for religion and death.

PE 2.S170

Palliative care at home for the dying: A two years experience in communicating with AIDS patients at end of life due to antiretroviral treatment failure in Abidjan, Côte d'Ivoire

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Aims: The main objective pursued by Ruban Rouge CI- an HIV/AIDS organization- when opening the palliative care unit in December 2005 was to continue providing total care at home (physical, psychological, spiritual) to the dying AIDS patients who faced treatment failure amongst the 2113 persons who were under antiretroviral treatment at the organisation AIDS clinic in Abidjan.
Method: The study is a retrospective analysis of counselling based interviews carried out by palliative care staff with AIDS patients at end of life as well as their family members between March 2006 and June 2008. Interviews covered patients' emotional, social, and spiritual needs and problems. Patients and family members interviewed were aged 24 and more. Touching was also used an interview technique with patients. In total 81 patients and 50 family members were interviewed.
Results: Analyses showed that 2 months after they entered the palliative care program fear was the main problem at the patient level. Indeed,
1) 84% among them had fears about their family and friend. The feelings they expressed the most were: loss of family role, being a burden, loss of sexual attraction or sexual function;
2) almost half of the patients (39) had fears about dying because of religious concerns;
3) 40% expressed fears about social status and finances.
On the family ground, the main problems were:
1) lack of experience with death occurring at home,
2) ignorance of legal rights of their dying ones to confidentiality and ethical issues related to disclosure without the patient consent.
Conclusion: Given that a growing number of AIDS patients under ART in Cote d'Ivoire are faced with treatment failure and that second line treatment are not affordable to most of them, the need for palliative care is increasing within this specific population. Potential palliative care providers will need strong counselling skills to deal with patients' fears and promote confidentiality within family members.

PE 2.S171

Factors to identify palliative care patients with malignant and non-malignant disease, results from a literature search and expert panel meetings

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Palliative care patients are not always recognized as patients who are in need of palliative care. Especially for patients with Chronic Obstructive Pulmonary Disease (COPD) or with congestive heart failure it is hard to say when they can benefit from palliative care. For patients not recognized as palliative care patients a plan of action is missing. In literature various approaches are used to identify patients at the end of life. Studies used specified characteristics, survival prediction rules or physician judgment. But no literature was found with validated tools which can identify palliative care patients.
Aim: The aim of this study was to identify factors which can identify patients with COPD, congestive heart failure and patients with malignant disease, who can benefit from palliative care in general practice.
Methods: A systematic literature search was performed and expert panel meetings were held to identify factors which can identify palliative care patients with COPD, congestive heart failure and patients with malignant disease, who can benefit from palliative care in general practice.
Results: In literature we identified 25 possible factors for identifying palliatieve care patients with COPD, 29 factors for patients with congestive heart disease and 39 factors with a malignant disease. Expert panels identified a list of 34 possible factors for identifying palliative care patients with COPD, 14 factors for patients with congestive heart failure and 12 factors for patients with a malignant disease.
Conclusion: A lot of different possible factors were found to identify patients with malignant and non-malignant disease, who can benefit from palliative care in general practice. The amount of factors is possibly not effective to use in general practice. More research is needed to reduce the amount of factors in order to get a successfully and effectively list of factors which can help to identify palliative care patients in general practice.

PE 2.S172

To die in an internal medicine ward in Sweden today

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In internal medicine wards in Sweden today, a common group of patients are the elderly with multiple diseases in the last phase of their lives. Though the medical staff daily takes care of dying patients there is a lack of knowledge and routines in basal palliative care.
The Swedish national register of palliation aims to improve the care of dying patients. Hospices as well as home care units and hospital wards are encouraged to register data concerning all their deaths.
In ward 353 at the Clinic of Internal Medicine, Sahlgrenska University Hospital 90 patients die annually. In spring 2007 we decided to join the register to be able to characterise the quality of our palliative care and improve it just by the process of registering. During the period 070501-080831 there were 121 cases of death reported of which 85% were expected. Only 24 % of the patients but 80% of their relatives had been informed that they were dying.
17% were not relieved from dyspnoea, 17% not from pain, 20% not from wheezing, 6% not from nausea and not 20% from anxiety.
The number of patients that were prescribed medication against pain increased from 74% to 100%; against wheezing from 52% to 83%; against nausea from 10% to 67% and against anxiety from 48% to 92%.
40% of the patients died alone - a figure that varied from 60% to 27%. 60% died in the absence of relatives or friends - a figure that varied from 85% to 30% and correlated to the frequency of dying alone.
A bereavement meeting was offered in 52 % of the cases - 22% in the beginning of the study period and 90% in the end.
The results from 16 months of registration show several areas where the palliative care has to be improved but it seems that the registration itself had a positive effect on several parameters. As the whole clinic with 158 beds now register all cases of death it should improve the quality of palliative care for the approximate number of 350 patients that dies at our clinic each year.

PE 2.S173

Delving deeper - Further analysis of cancer deaths audit

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Background: Towards the end of 2006 an audit of all cancer deaths, in all care settings, occurring within the West Lancs, Southport & Formby area was undertaken. Preliminary results showed that about 2/3 of those who died had made their wishes about their preferred place of care known to health professionals and approximately 3/4 of those chose to be at home. Of the 1/4 who chose not to be at home, all got their wish, but of the 3/4 who chose to die at home just over 1/2 of these achieved it. Significantly, if the carer's wishes were that the patient should not die at home, none did and if the family were undecided only one patient managed to die at home.
Method: Although the data was incomplete, it was important to understand whether there were lessons that could be learnt from the data available. The data was analysed using SPSS (data analysis package), to look further at reasons for either staying at home or not staying at home.
Results: This poster displays the results of the further analysis and the contributing factors which were discovered to be important in achieving expressed end of life wishes.

PE 2.S174

Quality assessment of I.S.T. Home Care Program

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Aims: Our research is intended:1) to evaluate patients (pts.) and their caregivers' careg.)satisfaction in I.S.T. Home Care Program (HCP); 2) to detect needs of pts. and their careg. communication and information.
Methods and patients: In this research had been included all advanced cancer pts. with a life expectation beyond 1 month, followed in home care for more than 15 days at least. Both pts.and careg. had been interviewed once by an external team of psychologists separately. Careg. had beeen interviewed once more.The eligible pts. were 21, whose 12 accepted to be interviewed, 2 turned out, 7 have been excluded because their clinical conditions got worse. 19 Careg. accepted to be interviewed for the first time.Thesecond interview was possible for 9 careg.
Results:
A) Patients: most of the pts. learnt the I.S.T. HCP during their stay at hospital or during follow up visits. 9 pts. out of 12 considered good the level of information, staff's kindness and ongoing care between hospital and home.The quality of information concerning disease and staff willingness were considered good. A third of pts. obtained a partial response by the pain therapy; while those who referred other symptoms obtained a good response. On the whole HCP was judged good for 8 pts. and very good for 3 pts.
B) Caregivers: They consider good the level and comprehension of information and staffs' attitude too. In addition to the I.S.T. HCP 16 out of 19 needed private and integrated assistance. Our Program was evaluated positively, they appreciated the staff´s competence and willingness. They would like to benefit of much time of home care, more information and economical aids.
Conclusions: Both pts. and careg. claimed for a deeper knowledge concerning disease and socio-sanitary aspects. We drew up an informative booklet of practical use about the Palliative Care Regional Services.
This Research has been carried out thanks to a grant of the Italian Health Ministery.

PE 2.S175

Patterns of care in the last 4 weeks of life in patients with solid tumours at a Swiss cancer centre

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Rational: There is no gold standard for interventions in cancer patients closed to death, but some indicators for "non- quality" are stated in the recent literature. According to an American expert panel, indicators for low quality of life in the last weeks of life seem to be: start of new chemotherapy in the last 30 days, continuation of chemotherapy in the last 2 weeks, more than 1 hospitalisation and stay at ICU in the last month. The debate on "futile treatment" and "medicalisation of dying" is ongoing, and cost - benefit evaluations are rare for this phase of life.
Methods: A retrospective, electronic chart review of all patients with diagnosis from cancer (solid tumours) who died from 2004 - 2006 was performed at our hospital. Each chart was screened in regard of the indicators mentioned above (inpatient and outpatient). In addition, radiotherapy, major surgical interventions and blood product- transfusions in the last 4 weeks were analysed.
Results: 521 patient charts were analysed, drop out due to missing data n= 27. In the remaining 494 patients most frequent diagnosis was lung cancer (23%), followed by upper GI (20%). New anti-tumour treatment 4 weeks prior to death was initiated in 30% (n=148, chemotherapy 13%, radiotherapy 8%, major surgery 13%), and 31% received such treatment even in the last 2 weeks of life (chemotherapy 15%). Blood products were given in 50% of patients during the last 4 weeks, with 23% during the last week of life. 15% had ICU admission during the last 4 weeks.
Conclusion: Stating quality indicators for best end- of-life cancer care may be very much dependent on individual factors, but the high percentage of anti-tumour treatment even during the last two weeks of life might initiate a more intense debate on goals and cost-benefit analysis within our centre.

PE 2.S176

Non-governmental organizations´ contribution to end of life care in Argentina

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Since first initiatives in the early 80's, Palliative Care(PC) in Argentina has been significantly developed. Despite of this, PC services remain insufficient. Financial constrains, inequality in access and distribution of health resources, lack of proper health policies and strategies, and poor governmental support, are key hindrances to its growing. The national health system provides 100% free care and medication to hospital inpatients, with rare or no follow-up or medicines provision for chronically ill or dying patients at home. There are no general practitioners, the nurses/doctors ratio is extremely low and trained PC professionals are still scarce. Nevertheless, non-governmental organizations(NGO) and few private institutions have played a seminal role in PC delivery, intending to fill in the existing gap regarding home care. This study aimed to describe where patients assisted by a NGO home care team died; analyze factors that may have influenced the place of death; and determine utilized resources during the assistance. Overall aim: show the impact of a NGO program in care at the end of life. Information was retrieved through retrospective review of medical records of cancer patients who had been admitted to a NGO home care program and died, within a period of 12 months. Records were excluded due to missing information. Data from 76 adult cancer patients have been analyzed. 66 Patients (87%) died at home. Features such as type of tumor, time between admission to the program and death, place of residence and family support demonstrated to be associated with the place of death. PC professionals involved and other required resources were enumerated. This study showed the impact of NGO commitment and participation in PC, improving quality of care of patients and families at the end of life, through the optimization of low resources and a specialized PC team.

PE 2.S177

Geriatric hospice - Eight years experiences of home hospice for adult in Pozna?/ Poland

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At present, all societies are dealing with an increase of the number of elderly people which needs or will be needs a paliative care in endstage of their live. In this paper we present our exeperiences in paliative care for patients over 65 years without neoplastic diseases. The home hospice care we realise by multidisciplinary team consists from medical specjalists - for paliative, geriatric, internal medicin, hematology, neurology, surgery, nephrology, diabetology, cardiology, anesthesiology, dermatology and nurses prepared for palliative care. They were supported by psychologists, physiotherapists, social workers, priests and group of volunteers trained for hospice care. During nine years, we provided the care for nearly 2000 persons. In this group, 70,0 % of patients were with non-neoplastic diseases (female - 56,8%, male - 43,2%; mean age: 78 ys., range: 65-102 ys.). There were patients with painful and large bedsores - 64%, arteriosclerosis - 33%, Alzheimer disease - 16,5%, diabetes - 15,5%, senile demention - 14,5%, Parkinson disese - 10,7%, cerebral stroke - 8,7%. The most medical problems were: urine and feces incontinence, bedsores, dehydratation, general devastation and pain. The mean time of care was 5,8 months, but about 18% of patients needed over 1 years care. This work indicate that older people with non-neoplastic disorders need the same care similar to the young patients with neoplasa. During nine years our Home Hospice for Adult constructed an effective model of palliative for elder people based on two criteria: complexity and accessibility.

PE 2.S178

Nationwide and graded hospice and palliative care in Austria - Dream or reality?

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This research aimed at clarifying the necessary measures to implement nationwide hospice and palliative care in Austria until 2012. Further the research aimed at visualizing the work of voluntary and salaried personnel.
In order to achieve these aims it was necessary to survey the current status of hospice and palliative care in Austria. As a further stage the statistical data was compared to the recommended data of demand of ÖBIG (Austrian Health Institute). The theoretical level of nationwide hospice and palliative care was then compared to regional reality and daily experience. The collected data was written into the SQL database of Hospice Austria and analysed. The data collection was carried out by the structure of Hospice Austria.
The outcome shows the necessity of considering regional conditions. Demand and level of nationwide care mainly correspond regarding palliative care units, especially in metropolitan areas. The demand for inpatient hospices is high. The perception of demand for day hospices varies greatly. Calculations of demand and nationwide care for mobile palliative care teams are widely accepted. The primary basis for calculations is human resources (4,5 full time equivalents per 140.000 residents) and secondly the amount of teams.
Hospice Austria and the federal states coordination organizations regard a nationwide implementation realistic if there is enough political will at federal and state level. This means a good coordination of funding responsibilities between the ministry of health, the ministry of social affairs, and social insurance institutions, which in turn would lead to generally applicable rules of financing and the inclusion of all hospice and palliative care services into the standard care of the Austrian health care system.

PE 2.S179

The effect of the palliative care team on quality indicators for end-of-life care in the Intensive care unit: a randomised, controlled study

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Many problems exist in managing patients at the end-of-life in the intensive care unit (ICU) and involve a complex interplay between the patient, their families, technology, and the treating medical teams. The act of end-of-life decision making can be difficult and practices can vary widely.
We conducted a single centre, unblinded, prospective, randomised controlled trial, at the Concord Repatriation General Hospital, Intensive Care Unit, Sydney, Australia, with Ethics approval.
The priori hypothesis was Palliative Care teams improve patient, family, and staff satisfaction with end-of-life care in ICU.
Patients who had begun end-of-life care in the ICU were randomised into two groups.
Control Group: received normal ICU end-of-life care, including preparation of the patient, family, and staff, symptom management, withdrawal of treatment, and communication.
Intervention Group: received normal ICU end-of-life care, and in addition, involvement from a palliative care team.
We looked at the effect of the palliative care team on three groups: patient and their families, nursing staff, and medical staff via questionnaires.
The primary outcomes were:
(1) overall patient/family satisfaction with ICU treatment.
(2) continuity of care, emotional support, symptom management, and spiritual support.
(3) staff satisfaction with ICU.
(4) Length of ICU stay. (5)Length of hospital stay.
Secondary Outcomes were: As listed under the end-of-life care domains such as symptoms (eg. pain, dyspnoea), and communication quality.
These outcomes were based on quality indicators for end-of-life care, by The Robert Wood Johnson Foundation Critical Care End-of-Life Working Group that identified seven key domains.
This study has been completed in October 2008 with 20 patients recruited. The study further highlighted the

difficulties in recruitment in ICU. Statistical analysis of the study is underway and these results will be presented and discussed during this presentation.

PE 2.S180

MRSA in the palliative care unit: An increasing problem?

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Aims: The aims of this study were threefold. Firstly, as this is a follow up study, we wanted to determine if there had been an improvement in clinical practice in relation to screening for MRSA. Secondly, we wanted to determine the prevalence of MRSA in all patients admitted to the palliative care unit, and thirdly to determine to what extent the screening identified new MRSA cases.
Methods: A retrospective chart review of all patients admitted to the 36 bed palliative care unit over a four month period was undertaken. All patients were screened for MRSA within 48hrs of admission. Prevalence of MRSA colonisation, site of colonisation and clinically significant infection were documented. All referral forms, available MRSA screening results, and documentation (for patients transferred from hospital) were reviewed on each patient to determine whether they were already known to be MRSA positive before admission. Results were compared with results from the previous audit.
Results: There were 133 admissions within this period, 66% (84) of these were admissions from home. The prevalence and incidence rate of MRSA colonisation was 14% and 3.9% respectively. Two further patients (1.6%) became colonised with MRSA in additional sites during their admission. Screening data was available for 74.8% of admissions as compared with 22.7% in the previous study.
Conclusion: MRSA remains prevalent in this palliative care unit but practive in relation to MRSA screening has improved since the previous study. Further research is underway to explore the impact of MRSA in the palliative care setting.
This study was not funded.

PE 2.S183

Can randomised whole population surveys better estimate rates of chronic breathlessness in the adult population?

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Introduction: Given the progress in the symptomatic treatment of breathlessness, estimates of the size of the target population who may benefit from better palliation become imperative. To date, prevalence estimates have varied widely (0.9% of clinical encounters to 27% of the broader population) and been limited by reliance on respondents who used clinical services. Whole-of-population approaches may be able to better define the 'true' prevalence of chronic breathlessness and help quantify associated functional impairment. The aim of this study was to determine whether a whole-of-population randomized survey could help to estimate chronic breathlessness.
Methods: A whole-of-population random survey method (n = 4366) in South Australia was used, standardized for age, gender, country of birth and rurality. Respondents were asked about breathlessness and limits to daily function affecting them for at least three of the last six months using a modified Medical Research Council dyspnea scale. Descriptive data with univariate and multivariate analyses identify the demographic characteristics of people more likely to experience chronic breathlessness.
Results: With a participation rate of 66%, 2.2% of respondents have breathlessness that is likely to interfere markedly with day-to-day activities. Significant associations with chronic breathlessness in multivariate analysis (correctly classifying 68% of the population) include being female (p<0.001), not working fulltime (p<0.001), not being married (p=0.011) and having a lower final educational level (p=0.016).
Conclusion: There is a significant burden of ongoing breathlessness in the community. Given the prevalence, it is feasible now to use a population approach to explore the onset of breathlessness, the underlying aetiologies and subsequent health service utilisation.

PE 2.S184

Future projections of population and mortality to 2030 in Germany - And their impact for end-of-life care

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Background: The world population is aging and this applies in particular to developed countries such as Germany.
Aim: To analyse future population and mortality projections in Germany to 2030 and discuss the impact for end-of-life care.
Method: Secondary analysis of official national statistics data regarding population, births, deaths and places of death. Future scenarios for hospital deaths were modelled using recent ten-year trends in age and gender specific proportions to estimate numbers of hospital deaths to 2030.
Results: Future projections of population estimate a 6.1% decrease in Germany (82.2/77.2 Million in 2007/2030) with a fast aging population at the same time. The population at working age is diminishing, because of a low birth rate (since the early 1970s). Life expectancy is still increasing (+7 years). However, the numbers of deaths started to rise in 2006 and will increase to 1.001.000 deaths in 2030 (+21.8% compared to 2006), because the 'baby-boomer' generation from the 1960s is coming into age. By 2030, the dying in Germany will be much older in comparison with today. If the proportion of hospital deaths continues to be 47% of total deaths in Germany, the absolute number of deaths in hospitals will increase from 393.715 (2005) to 468.000 (2030). Data about place of death in Germany other than hospital are lacking.
Conclusion: Germany is facing major challenges with increasing numbers of deaths and aging populations. There is an urgent need for planning care to accommodate growing end-of-life care needs. Although these changes were felt sooner and to a greater extent compared to other countries (e.g. UK), a national strategy for end of life care is still missing.

PE 2.S185

Interval between cancer diagnosis, first palliative care consult and death in a palliative care unit in Argentina

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Introduction: Most referrals to palliative care (PC) services occur late in the disease process. Much information about this topic is available in the literature, but there is no data from this issue in Argentina.
Objective: To determine the interval between Cancer Diagnosis (CD), first PC Consult (PCC), and Death (D) in a Palliative Care Unit in Argentina.
Methods: Retrospective charts reviewed of 194 consecutive deaths during 2007. Information about demographics, date of cancer diagnosis and date of first palliative care consult and death, were collected.
Results: 108 (56%) patients were male. Mean age was 64 years old (range 32-92). The main cancer diagnosis were lung 27%, gastrointestinal 26%, breast 11%, urinary 6%, and prostate 5%. Only 7 patients had no cancer diagnosis. Median survival from diagnosis was 263 days (range 5-4590 days).Median interval between CD and PCC was 133 days, and interval between PCC-D was 45 days (range 0-1482 days).
Discussion: In this study most of the patients had advanced cancer at the time of diagnosis. Referral to the palliative care consultation was in the middle of the trajectory of the disease. This data correlates with international publications. Future research will be necessary to assess if the PCC was mainly related with prognosis or with the de intensity of distress. Continuing education in the community and in the health care team will enhance earlier access to palliative care.

PE 2.S186

Hospitalizations in a palliative care unit (PCU) in Argentina

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Introduction: Only a very small number of inpatient palliative care units are available in Argentina. The Hospital Tornú-Fundación FEMEBA PCU aims to offer specialized interdisciplinary assistance to patients and their families who have high level symptom and psychosocial distress due to advanced illness that threatened their lives.
Objective: To describe the characteristics of patients admitted to an inpatient PCU.
Methods: Retrospective data reviewed from clinical charts of patients admitted to a 4 bed inpatient PCU during 2007. Demographic data, type of disease, reason for admission, discharged destination and length of stay were collected.
Results: 75 admissions corresponding to 68 patients were collected. Mean age was 60 years old (range 20-92). The main cancer diagnosis were gastrointestinal 40%, lung 12%, urinary 12%, breast 9% and prostate 7%. Median length of stay was 11 days (range 1-137). 67% patients died hospitalized and 27% were discharged home. The main reasons for admission were delirium 31% (23/75), infections 29% (22/75), family distress 29% (22/75), pain 19% (14/75), and dyspnea 12%(9/75). No reason for admission available in 29% (22/75). Performance status on admission was 3-4 in 88%.
Discussion: The most frequent cancer diagnosis admitted to the inpatient PCU was gastrointestinal, generally with colostomies, bad general condition, and difficulties with oral intake. This was probably why delirium and infections were the main reason of admission. This generates more caregiver burden and distress, with longer stays, and difficulties to discharge home, as there was no home care available in the argentinian public health system.

PE 2.S187

Cornea donation from a palliative ward

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Aims: Contrary to most human organs the cornea can be harvested for transplantation up to 72 h after death. Furthermore, cancer (with exception of haemoblastosis) is not considered as contraindication. Studies of hospices in Great Britain indicate that corneal donation is generally regarded positively by donor family members. The goal of this study was to investigate the ability to obtain consent for cornea donation in a palliative care ward in Germany.
Methods: Over a period of 6 months patients admitted to the palliative care ward were first assessed on exclusion criteria for cornea donation. Depending on the patient's ability to give informed consent the patient or his relatives were then approached and asked for consent to cornea donation. Patients or relatives were only approached if - by judgment of the responsible physicians - the question for cornea donation would not represent an undue stress for them. The screening process and results were documented on a flow-sheet.
Results: From a total of 92 patients the screening process was documented in 86. 12 pts (14%) had exclusion criteria for cornea donation. From the 74 remaining , 58 (78%) were regarded to be able to provide informed consent. 6 patients were asked for cornea donation; 5 agreed. From the remaining 52 patients 33 passed away on the palliative care ward. In 14 of them the family members were asked to give consent after death; 2 agreed. Form the 16 patients (22%) unable to give informed consent 4 out of 6 approached families agreed. Thus, of the 74 eligible donors or families of eligible donors, a total of 26 (35%) were asked to give consent, resulting in a rate of 11/26 (42%) agreeing to cornea donation (12% of the total of 92 patients admitted).
Conclusion: The particular stress situation of patients and their families on a palliative ward requires great sensitivity when asking for cornea

donation. However a substantial number of those patients or families approached are willing to donate.

PE 2.S188

Structured ethics consultation in a university hospital - First data

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The existence of ethics committees providing education in medical ethics, development of guidelines and performing ethics consultations is not common in German speaking University Hospitals. The task of an ethic consultation is to identify and analyze a conflict of values and facilitate a consensus for the best possible solution.
In this retrospective study, the documentation of the structured ethics consultations in the first thirty months after implementation at a University Hospital, were analysed. A team of at least two persons from the ethics committee had done each consultation. Without extraordinary activities, the ethics consultation team was well accepted by the medical staff and other care giver. Forty one consultations were performed, 29 (70,7 %) of them on intensive care units. One third of all consultations were characterized by complex situations (e.g. medical decisions, communications difficulties) without a clear ethical question. Thirty four (82,9%) patients were not able to give informed consent. More than two third of the consultations (n=28) were requested for in end-of-life-situations.
Despite the fact that a University hospital treats the most complicated courses of diseases, most of the requests were for questions in end-of-life-care. This is in contrast to other findings. Also all consultations without any clear ethical questions were performed in end-of-life-situations. Obviously medical staff associated ethical questions at the end of life, perhaps because of the emotional burden and the documented inability of the patients to give informed consent. The need for communication in this situation is high and consultation teams can ease the communication. The overlap of palliative care and ethics consultation is well known. Particularly regarding this fact it is necessary to clarify the tasks.
In the future we expect a shift to other prospective consultations for clinical decision making including questions of resource allocation.

PE 2.S189

Re-socialization of prisoners in hospice? Opportunities and barriers in the light of the research made in 15 correctional and palliative care units in Poland

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Aim: From 2003 in Gdansk, prisoners, towards the end of their re-education process, have worked in the palliative care unit. They become part of the interdisciplinary team, collaborating successfully in the caring team (Krakowiak P, Volunteers dedicated to the care of sick elderly people, Dolentium Hominum 1/2008). Hospice Information Bulletin commented: "Prisoners in a hospice? Why not? An innovative program to reintegrate prisoners into society through voluntary work has proved useful at Gdansk Hospice" (Sentenced to care, November 2007). More than 400 prisoners have worked as volunteers in hospice, and more than 40 finished the nurse aid training working among terminally ill.
Methods: Based on the five-year long experience of positive collaboration, the national pilot program has been proposed. WHAT: Work in Hospice as a tool of Acceptance and reciprocal Tolerance, with 15 hospices and semi-open correctional facilities have started in 2008 with the patronage of Ministry of Justice of Poland. This program gives a chance for carefully selected and prepared prisoners, teaching them a new profession of nurse aid helping the terminally ill (Krakowiak P., Podr?cznik koordynatora wolontariatu hospicyjnego, Gda?sk 2008, 53-56).
Results: Coordinator in on of 15 of palliative care units involved in this project and correctional facilities educator will monitor one of the prisoners helping in hospice. The results will be presented at the end of the WHAT program in April 2009.
Conclusion: This program will show the possibilities of cooperation between correctional facilities and palliative care units. The positive results will allow writing the program of selection of prisoners and guidelines for hospices to allow the voluntary activities and nurse aid training. If the program will be successful it will be implemented in more palliative care units in Poland. It might be another method of improving the quality of care and breaking various stereotypes in the society.

PE 2.S190

In seeking the miracle cure, or the use of alternative treatment modalities amongst cancer patients in Bulgaria

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There is growing popularity amongst cancer patients to use alternative treatments. Often the patients are fascinated by the advertisements or deceived by unscrupulous tradesmen. These alternative treatment modalities often lack of evidences for their effectiveness. In Bulgaria these kinds of treatment usually are not ordered by the oncologists. Even more, often the alternative treatment is performed by the patient itself without consulting with the responsible oncologist.
In the investigation were asked 200 patients about their use of alternative treatments. The ways patients gather the necessary information are described. The patients were separated by gender, age, religiousness, education and place of living. The preferred alternative treatments are listed.
Although 97% of the interviewed patients declared trust in official medicine 6% of them searched help in alternative medicine before starting the anticancer treatment. 47% of the patients have concomitantly used alternative treatments. 50% of the patients have used alternative treatments in the periods between active anticancer treatments.11% of the patients asked their oncologist before starting the alternative therapy and 46% did not. 57% of the patients who have used alternative treatments did not inform their oncologist because of different reasons. 60% of the interviewed stated that they would like more information about the different alternative treatment modalities. 98% of the interviewed stated that their oncologist had never suggested alternative treatments Cancer patients tend to use alternative treatments in hunting of the miracle cure. They prefer to get the needed information from their oncologist. The lack of evidence based information about the effectiveness of the different alternative treatment modalities, force patients to trust the pseudo-medical commercial newspapers offering miracles in every issue.

PE 2.S191

Gender: Ethical issues in long-term care

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Aim: Ethical issues in end-of-life care decisions within long-term care are gainig importance. Gender relations on structural, interactional and personal levels play an essential role in the decision making processes regarding ethical questions. The aim of the study is to show in what situations and ways gender affects ethical issues within the care for frail elderly in nursing homes.
Methods: Working within the qualitative paradigm, situations and examples of ethical questions have been elaborated together with interdisciplinary care teams. These different situations have been analysed from a gender perspective. Themes and roles within the narratives have been identified. Sociogrammes helped to demonstrate the different relations within the care arrangements.
Results: Looking at experiences with ethical issues in long-term care we can see the significance of asking gender related questions. The situations we have analysed showed "autonomy" and "desire for relationship" as crucial themes at the personal level of the frail elderly. Gender effects can be described as differences between male and female persons dealing with those themes. On the interactional level we found that traditional family patterns dominate gender-related communication. On a structural level the central finding is the overwhelming evidence of long-term care as "womankind nursing home".
Conclusions: Gender itself can be described as an ethically relevant category. For management and professionals within long-term care it is important to have an understanding of gender-sensitive care-giving. This encompasses communication and decision making processes that give frail elderly a chance to be heard and understood irrespective of their gender. On the structural level Gender Mainstreaming can be a helpful tool for taking the ethical dimensions concerning gender within long-term care into consideration.

PE 2.S192

Representations of end-of -life, palliative care and of withholding and withdrawal of life support in intensive care units: Interest of collaboration with a mobile palliative care team

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Aims: The death rate during intensive care unit (ICU) is high (20% of admitted patients). 50% of deaths happen after medical decision-making. In France, the 22nd April 2005 law gives legal references which complete recommendations of scientist societies such as SRLF (Société de Réanimation de Langue Française). The aim of this study is to have a better knowledge of the representations of the caregivers from different professions all working in ICU.
Methods: Eleven semi-directive interviews were performed with different caregivers (physicians, nurses, care assistants, healthcare executives, physical therapists and social worker). The results were examined through a theoretical angle of social representations, complexity and of the "outside partner".
Results: ICU caregivers have different attitudes according to their professions, which are marked by their heterogeneous personal experiences of end-of-life. Their knowledge about palliative care and official texts about withholding and withdrawal of life support are poor. A confusion exists about the definition of euthanasia. Clinical and therapeutic difficulties, organisational difficulties and difficulties linked with accompaniment are among the most noticeable ones. They don't know palliative care and mobile palliative care team (MPCT) enough. Add to this the problem of written traceability.
Discussion and conclusions: These situations include characteristics of "complex situations". The theory of complexity, by Edgar Morin, gives us a clue about the method to resolve these situations. The MPCT can play the part of a "reflexive third" in collaboration with the ICU teams. The written process is an important component of articulation with the speaking process. Recommendations are suggested to develop the palliative approach in ICU and the mediator capacities of the MPCT in complex situations. Collaboration between a ICU team and a MPCT seems useful for complex situations and depend on good mutual knowledge.

PE 2.S193

'Vulnerability' in cancer and palliative care research: Findings from a qualitative study of Black Caribbean and White British patients with advanced cancer

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Aim: Vulnerability is a poorly understood concept in research ethics often aligned to autonomy, consent and clinical research, rather than other research approaches and contexts which may raise different issues. This study therefore examines issues of vulnerability in cancer and palliative care research obtained through in-depth qualitative interviews.
Method: Secondary analysis of in-depth qualitative interviews among 26 Black Caribbean and 19 White British patients with advanced cancer living in south east London. Patients were recruited from in-patient and community-based palliative care teams in addition to out-patient oncology and lung clinics. Interview transcripts were analysed using the framework approach.
Results: Four domains of vulnerability were identified from the interview transcripts;
(i) communicative vulnerability due to distressing cancer-related symptoms;
(ii) institutional vulnerability among participants who were cared for in hospital settings;
(iii) deferential vulnerability which refers to perceived inequalities between the researcher and participants;

(iv) medical vulnerability among those with multiple and complex health problems and needs; and
(v) social vulnerability which refers to participants from undervalued social groups, for example black and minority ethnic groups.
Conclusion: Current interpretations of vulnerability require re-interpretation when applied to qualitative and end of life research. We make recommendations for researchers and Research Ethics Committees when considering this research approach, and the specialist skills required when conducting it.

PE 2.S194

Consideration of palliative principles in persons with cognitive impairment and life limiting disease

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Aim: Decision-making in individuals with cognitive impairment (mental retardation, post-traumatic vegetative state, dementia) is a medical, legal, philosophical and ethical challenge. Especially in different states of dementia when the person concerned is confronted with a life limiting disease the question arises if patients with cognitive impairment are able to state consistent choices or to what extend the surrogates are involved to make decisions on their behalf.
Methods: Three case histories with different forms of cognitive impairment (mental retardation with severe impairment, post-traumatic vegetative state and progressive dementia) with concomitant life limiting disease are analysed on the criteria for the consideration for withholding or withdrawal possibly life prolonging medical activity.
Results: Besides prognostication for the effectiveness of a medical act, respect for autonomy, individual values for the quality of life by the interpretation of mimic and gestic expressions, compliance, social relations and resilience have to be related to each other very sensitively when life prolonging treatment is changed into palliative care in persons with cognitive impairment. The consideration of anticipated directives can be helpful in interpreting the actual will. There should be consent of all giving care.
Conclusion: Clinical indication for palliative care in persons with cognitive impairment needs very careful assessment of all aspects of medical decision making, consent of all and transparency in the best interest for the person concerned.

PE 2.S195

An ethical critique of Best Supportive Care (BSC) studies in oncology

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Since 1988 there have been over 40 oncology studies in patients with advanced and incurable cancer that have included ´Best Supportive Care" or "Supportive care" as a control arm or as an ancillary aspect of care. Detailed review of these studies reveals that they can be subcategorized into three types
1. Treatment compared to BSC (X vs. BSC)
2. Treatment plus BSC compared to BSC alone (X+BSC vs. BSC).
3. Treatment vs. non treatment, all patients receiving ancillary (X vs. nil).
Palliative or supportive care delivered in the overwhelming majority of these studies represents the usual practice of the participating researchers. In general it is poorly described, haphazard and is not in accordance with any referenced standards of practice. The studies will be reviewed using Emanuel's 7 requirements for ethical of clinical research studies (1. social value, 2 scientific validity, 3 fair subject selections, 4 favorable risk-benefit ratios, 5 independent reviews, 6 informed consent and 7 respect for enrolled subjects) and the Declaration of Helsinki.
The presentation will highlight
1. Regarding Social Value: Where as there is value to demonstrating that chemotherapy my be better than no chemotherapy, the invocation of SC and the failure to institute any standards to ensure that patients receive quality care undermines the social value of this paradigm.
2. Many of these studies contravene articles 11 and 29 of the Helsinki Declaration.
3. Regarding scientific validity: The design fault that is manifest is designs 1 and 2 are not present in design 3 which is a more scientifically valid approach to questions of the value if any of further disease modifying treatment.
Recommendation will be presented regarding study design, methodology and standards for this genre of studies.

PE 2.S196

Limitation of medical treatment at the end of life: A qualitative study on UK oncologists' perception and ethical views

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Aim: Limitation of treatment is part of the care for patients with incurable cancer. We explored UK oncologists' perception and ethical views regarding these decisions. The paper summarises preliminary results of the data analysis, focusing on decision making criteria and oncologists' ethical views regarding patients' involvement in these decisions.
Methods: UK Oncologists have been interviewed by means of a semi-structured interview guide. Interviews were audiotaped and transcribed. Transcripts were coded by identifying major themes of the interviews and by constant comparison regarding similarities and differences over the whole sample.
Results: 11 medical oncologists took part in the study. Interviews' duration was between 33 and 54 minutes. Respondents named a variety of treatments which may be limited in the context of care for patients with incurable cancer. Next to common clinical criteria (e.g. performance status), highly individual aspects of the physician-patient relationship (e.g. parallels between physician's and patient's biographies) seem to influence these treatment decisions. "Discussions with colleagues" and "multidisciplinary team" were named as "correctives" to make the decisions less subjective. "Time" and "communication skills" were perceived as factors which further patients' acceptance regarding the limitation of treatment. In some cases "non-harming" treatment was given to patients who did not accept oncologists' initial recommendation to stop treatment. The duty "not to harm" was cited as the rationale to limit treatment even though patients' wished to receive it.
Conclusion: The preliminary results of this study indicate that decisions about limitation of medical treatment pose clinically as well as ethically complex challenges to oncologists. Potential strategies for dealing with these challenges in a professional and ethically acceptable way will be discussed.

PE 2.S197

Nurses knowledge and attitude towards euthanasia

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There are a lot of discussions within health care institutions about legalization of euthanasia in Lithuania. Euthanasia is not legalized in Lithuania.
Aim of the study: To assess knowledge and attitude of nurses in nursing hospitals towards euthanasia.
38 nurses were investigated; they work in nursing hospitals in Kaunas district. Questionnaire of 27 questions was created by authors.
Results: Most of nurses (71,1 percent) know that euthanasia is legalized in some Europe countries. Even 13 percent of nurses think that passive euthanasia is legalized in Lithuania. 61,9 percent of nurses agree with legalization of active euthanasia in Lithuania (?2=45,431; p<0,05), but 52,4 percent of nurses think that nurse should decide personally about participation in euthanasia deed.
Most of nurses (52,6 percent) designate that euthanasia is death with dignity and free of pain. Nurses, who can explain what is active and passive euthanasia to another, can say differences between them (?2 =24,146; p<0,05).
Most of nurses (89,5 percents) indicate that euthanasia contradicts to Christian ethic but 23,7 percent of respondents indicate that euthanasia doesn't contradict to human rights.
Nurses, who are against euthanasia legalization, indicate that religion make influence to attitudes towards euthanasia (86,7 percent), but media make little or don´t make influence to attitude of nurses to euthanasia (71,7 percent).
57,9 percent of respondents indicate that poor spiritual nursing care can be reason of euthanasia application for patients.
Age, family status, work record, experience of nursing on incurable family members don´t make influence to attitudes of nurses to euthanasia.
Conclusions:
1. Half of nursing hospitals nurses in Kaunas district assent for euthanasia legalization in Lithuania.
2. Most of nurses know what active and passive euthanasia is.
3. Main reason for euthanasia - euthanasia emancipates person from intolerable existence.

PE 2.S198

Written information and communication about palliative care: Which words are used?

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Introduction: Upon the disclosure of terminal disease, conveying the notion of transition to palliative care to the patient is a delicate step in patient management. It requires sensitive interpersonal skills from healthcare professionals, the choice of suitable words to convey bad news being a complex exercise.
Objectives: This study explores the words used for communication about palliative care in written sources of information delivered to patients managed through a palliative care network.
Method: We studied the content of information material used by the French palliative care networks: information documents for patients (IDP), information documents for general public (IDGP) and internet websites (IW). We collected data on: the presence of the term "palliative care" and its definition, the terms used to describe patients who can benefit from the healthcare network and the kind of care delivered.
Results: We studied 26 IDP, 25 IDGP and 30 IW. The term "palliative care" was used in 85% of these items (in 73% of IDP, in 88% of IDGP and in 93% of IW). In documents not containing the term "palliative care", other words were found: "continuing care", "accompaniment" or "pain management". A definition of palliative care was present in 33% of all items (15% of IDP, 24% of IDGP and 57% of IW). The terms used to describe the patients were: "person diagnosed with serious and/or progressive disease" (27%) "person at end-of-life" (23.5%), or "patient in palliative stage" (11%).
Conclusion: The information in the material studied, especially the IDP, are sometimes laconic and brief to avoid the sudden disclosure of a fatal prognosis. Patient information needs to be delivered throughout the management of the disease, carefully choosing and adapting the wording used to best suit the patient Written information thus seems inappropriate in this context.

PE 2.S199

Job satisfaction of palliative care doctors

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Aim: Working in palliative care is supposed to be associated with a high risk for professional burnout. Here we aim to identify motivation, stress factors, and individual coping strategies of physicians working in palliative care settings. Further, self-assessed specific professional and individual skills needed by palliative care physicians were defined.
Methods: Qualitative study interviewing 16 physicians working in different palliative care settings such as hospice, hospital, home care or private practice in Germany, Austria, Switzerland, and Norway. The semi-structured interviews lasted 45-60 minutes; subsequently qualitative content analysis was performed.
Results: The age of the interview partners ranged from 30 to 62 years. Work experience in palliative care was from 0.5 to 27 years. All participants reported a high professional satisfaction in the palliative care setting.

The motivation for this choice developed during the previous employments in anesthesia, medicine or pediatrics. The main arguments for choosing palliative care settings were the broadening of professional spectrum and skills - or to choose a specialty with more direct contact and commitment to patients. Work related stress factors were not attributed to patients or their relatives. In contrast, stress factors were mainly contributed to structural and organisational problems. The main resources and coping strategies were found in an intact and supporting family as well as in discussions with colleagues. For successful palliative care, abilities for communication and personal interactions were rated higher than specific skills in medical procedures.
Conclusion: We conclude a high job satisfaction of physicians in palliative care despite the demanding physical and psychological requirements. Improving communication skills should be a central element in the training of palliative care physicians.
Supported by research fund of the University of Applied Sciences Braunschweig/ Wolfenbuettel.

PE 2.S200

The loved ones process to insight when a patient is dying

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Background: How long time of insight and understanding the loved ones have to be prepared for the patients upcoming death can be important for the loved ones bereavement. The time of insight is a time for preparation that the patient is going to die and different strategies is necessary to manage this phase of life.
Aim: Investigate when during the illness process the loved ones understand that the patient was going to die and how the process to insight looks like. Which strategies did they use in order to manage this situation?
Method: In depth interviews with loved ones to patients who had died at the Oncology department at Sahlgrenska University hospital, Gothenburg. The loved ones were contacted a little more than a year after the death to inform of the study. 15 in-depth interviews was done and the interviews were analyzed by using a content analysis, which examines the visible, surface content and deals with the explicit meaning of the text. The Regional Ethics Review Board in Gothenburg has approved the study.
Result: Most of the loved ones was knowing that the patient was going to die but thought it would be sometime in the future and did not thought that death was so close in time. This way of thinking seemed to be a strategy to make it possible to live in the present day. If they talked about the upcoming death this was often done in an earlier phase of the illness time. First when the loved ones were not able to have any conversation with the patient they prepared themselves for the patients dying.
Conclusion: The loved ones almost always knew about the upcoming death even if they were acting as they did not understand. It seemed to be a strategy in order to make it possible to meet the patient in the present day and as a living person as long as life was going on.

PE 2.S201

Why do family carers in end of life care decline support interventions?

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Background: Family carers are central to supporting people with terminal illness at the final stages of life. Little is known about why potentially supportive interventions are accepted or declined by carers. An independent longitudinal evaluation of support services for family carers of terminally ill people, provided by organisations in the UK Third Sector, is currently being undertaken.
Aim of this paper: The aim of this paper is to explore explanations of why carers decline the offer of interventions.
Method: Help the Hospices, a national UK charity, funded 14 hospices and 1 Citizens´ Advice Bureau to provide a variety of interventions including social, emotional and practical support for carers, delivered in groups or one to one. The evaluation used mixed methods to collect data from carers to establish their reasons for accepting or declining services: questionnaire data (n = 64) and interviews with carers (n = 17). A descriptive and content analysis was undertaken.
Results: Of the 81 carers providing information 61 (75%) are female, 20 (25%) are male, and their mean age is 63.8 (range 39 - 83 years). Overwhelmingly carers who accepted the interventions (n=73) expressed high satisfaction, and all said that they were relevant to their social and emotional needs. Carers who declined services (n = 8) offered the following reasons: currently receiving enough support; problems taking time away from caring responsibilities; and concerns about privacy.
Conclusion: These findings indicate that carers may have a number of good reasons for taking up or declining services which include concerns about invasiveness. Service providers may need to provide a portfolio of different interventions to be responsive to carers needs.

PE 2.S202

Distress and burden characteristics of caregivers in a palliative care unit

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This study assesses psychological distress and burden symptoms among caregivers of patients staying at the palliative care unit.
This sample consists of the responses of 57 primary caregivers caring for patients dying at the palliative care unit. The data were collected from demographic and medical information about the patients and caregivers. Measurements included; Hospital Anxiety and Depression Scale (HADS) and short version of Caregiver Burden Interview (CBI). Means and standard deviations were computed to provide descriptive information on all measurements. Correlative analyses were used to examine the relationships between variables, and a t Student test was calculated to compare means.
49% of the patients were men, with a mean age of 75 years. The most common primary cancer sites were gastrointestinal (28%) and respiratory tumour (19%). Around 20% were not oncology patients. The mean time admitted to the palliative unit care was 11 days. 72% of the caregivers were women, with a mean age of 54 years. The most prevalent relationship to patient was son/daughter (49%) and spouse (35%). 77% of caregivers reported clinical psychological distress (total HADS score> 11), 56% of caregivers showed significant characteristics of burden (CBI score >17). High distress was significantly associated with the caregivers' burden ($r = 0.466$). The time since being admitted to the palliative unit care is associated with minor distress and burden in the caregivers ($p< 0.05$). Significant differences were observed between the relationship caregivers, son/daughter caregivers were more vulnerable than spouses to experience anxiety ($t =2.85$, $p< 0.05$) and burden symptoms ($t = 2. 038$, $p< 0.05$). Psychological intervention at the palliative care unit could be provided because of the higher burden related symptoms of anxiety and depression among caregivers of dying patients.

PE 2.S203

The family caregiver - Family doctor relationship: A comparison between palliative and chronic care contexts in Canada

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Aim: In Canada, family doctors are heavily involved in providing and/or coordinating both palliative and chronic care. Informational continuity of care (ICOC) is a care quality indicator in family medicine and its establishment necessitates developing a trusting relationship of information sharing between doctor and patient. There has been little explicit consideration of family caregivers' roles in establishing ICOC. We aim to address this knowledge gap by focusing on ICOC establishment among two Canadian family caregiver groups: those caring at the palliative stage and those providing longer-term chronic care. Objectives are to comparatively examine:
(1) relationships caregivers established with care recipients' family doctors;
(2) how these relationships changed over time; and
(3) issues related to information sharing between both parties.
Methods: This qualitative study is an exploratory pilot involving interviews (n=20) with both caregiver groups. Semi-structured interviews were transcribed verbatim and managed using N7© software. Thematic analysis was guided by investigator triangulation.
Results: Challenges exist in the development of a trusting relationship of information sharing between both caregiver groups and care recipients' family doctors. Issues of concern regarded how best to prepare for appointments and how to share information on behalf of the care recipient. Key differences between the caregiver groups emerged. Those caring at the palliative stage often had little time to build a relationship; this compromised trust-building and negatively affected ICOC.
Conclusion: The results of this exploratory pilot study have identified avenues that warrant further investigation. The care context, whether palliative or chronic, must be considered in further research given differences identified in this study.
Funding source: Canadian Institutes of Health Research New Emerging Team in Family Caregiving at End-of-Life.

PE 2.S204

Family dynamics in palliative care - A challenge in a multicultural world: An Australian perspective

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An individuals' culture and religion form fundamental parts of their make up and are particularly important when that person is seriously ill and in hospital. (1) Families of patients receiving palliative care are profoundly affected by the challenges of the illness. (2) Impending death, forces patients and families into a situation where otherwise functional family units may become dysfunctional. In avoiding facing up to impending death, one family member is often singled out as 'the problem'. The focus is then shifted to that family member rather than the patient.
The crisis of terminal illness in families is compounded by conflicting dynamics within the family unit. Palliative care staff face the ever-increasing challenge of caring for those patients whose religious and cultural needs may vary. This can include extended family members. (3) In clinical practice, the most useful approach to defining and working with the family is to allow the person and his or her family members to define 'the family' themselves.
Host cultures are often intolerant of the differences, which other cultures bring. (1)
The mainstream culture of Australia has its roots in the culture and traditions of Great Britain. Australia's population has changed dramatically over the last 40 years due to immigration from other parts of the world including Europe and the Middle East.
This presentation seeks to give a better understanding of the various challenges involved in the religious and cultural aspects of palliative care from an Australian perspective.
References:
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PE 2.S205

Visiting all hours? The views of hospice staff on the visiting policy

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Aim: Open visiting (where there is no restriction on visiting times) is encouraged in hospices. This abstract reports the second (staff) strand of a qualitative exploratory study which has the aim of evaluating the impact of open visiting on hospice patients and staff. The patient strand had previously identified key issues to be: the need to keep in touch; visitor sensitivity; the physical/psychological impact of a visit; the need to be in control. This second strand aimed to establish staff

views of a hospice open visiting policy.
Methods: Three focus group interviews of representatives of hospice staff involved in patient care (total of 25 staff from the multidisciplinary team) were recorded, transcribed verbatim and analysed thematically.
Results: The main themes related to managing complex situations where visitors could hamper/facilitate patient centred care:
1. The importance of family and friends.
2. Being an advocate - using gentle persuasion or gatekeeping.
3. The family as part of the caring team.
4. Control versus powerlessness
5. Shared rooms: the impact on visitors and patients, e.g. visitors forming relationships with visitors of other patients.
A number of strategies for developing a flexible 'patient controlled' visiting policy were identified, including quiet times without visitors, restricting numbers of visitors in shared rooms and encouraging relatives to take a break from visiting.
Conclusion: The study supports and amplifies the findings of the patient strand of the study. While time is precious with family and friends, open visiting presents considerable challenges to staff, ensuring that all patient needs are met. The visiting policy may need modification to ensure it is patient centred, meeting the needs of patients and family at the end of life. The study was funded by the hospice where the research was carried out.

PE 2.S206

Overcoming a chronic illness with home care

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Background: Home care is the provision of comprehensive health and social services delivered at home.
Objectives:
1. To present a case of 49 year old, female with Meningioma.
2. To use family assessment tools to identify potential caregiver and resources.
3. To discuss the psychological problems confronted by the patient and the family.
4. To discuss the role of a home care physician and the basic home care skills necessary for the patient.
Methods: A patient with Meningioma was enrolled at the Family Health Care Program for Home care. Review on history and physical examination, and weekly visits were done.
Results: Meningioma is a chronic devilitative disease. Days became critical for the whole family: the disease, the expenses, and the caregiver. Despite all these problems the family remained highly functional (APGAR Score 10). Through the family's Genogram, primary care giver was identified. The family's SCREEM, proved that internal functioning was maintained. The main financial provider was likewise identified, and further strengthened by several external supports (ECOMAP).
Conclusion: Meningioma, a major burden to the family. To minimize the effect of the patient's illness and disability, Home care was provided. The role of the home care physician was fulfilled:
1. Healer. Prevent complications thru Basic Home Care and Wellness Program among family members.
2. Case Manager. Overall coordination of patient's care, utilization of community resources and, and empowerment of the family.
3. Counselor. CEA method for counselling and family meetings were done.
4. Educator. Education centered on family's understanding of the disease.
5. Researcher. Home care and long term management of meningioma.

PE 2.S207

Anxiety and self-efficacy in caregivers of advanced cancer patients

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Research aims: The diagnosis of cancer may create considerable psychological distress for caregivers such as increased anxiety, depression, hopelessness, and low self-efficacy especially for those who caring their relatives dying of cancer. Little is known for the role of anxiety and self-efficacy in caregivers of cancer patients in advanced stages. Thus aims of this study were to investigate anxiety and self-efficacy in advanced cancer patients in a palliative care unit.
Study design and methods: 107 caregivers of advanced cancer patients, treated for pain relief and cancer-related symptoms completed the General Perceived Self Efficacy Scale (GSE) and the Spielberger State-Trait Anxiety Inventory (STAI). The State-Anxiety scale evaluates how the respondent feels "right now, at this moment" and the Trait-Anxiety scale, how the respondent feels "generally".
Results: Statistically significant comparisons were found between anxiety levels and gender (p=0.009), cohabitation (p=0.002) and relativeness (p=0.004). Self-efficacious caregivers revealed a moderate anxiety (r=-0.260, p=0.007) and were more anxious in general (r=-0.383, p<0.0005) than those with low self-efficacy. In the multivariate analysis (enter method) with STAI as the dependent variable and all examined factors as independent, gender, relativeness and self-efficacy seemed to influence Spielberger-State. Additionally, results demonstrated that only self-efficacy contributes to the prediction of caregivers Spielberger-Trait.
Conclusions: In caregivers, levels of anxiety are significantly correlated with self-efficacy. Furthermore, anxiety seems to be influenced by gender, relativeness and self-efficacy. Findings in this study can help health care professionals focus on some problems common to caregivers of cancer patients and plan appropriate interventions and research to manage caregivers' symptom distress and promote self-efficacy.

PE 2.S208

Perceived quality assessment: Objectifying subjectivity

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Introduction: There are currently two departments in the Province of Trento (PT) that are specifically dedicated to palliative home care that directly provide care to those that are residents in the health care districts where these two departments are located (250000 residents).In the remaining areas (200000 residents),care is provided at home by GPs and home care nurses.
Aim: PT provides care in different manners, that are based on the location in which the patient is a resident.In order to ensure that all care is provided in the same manner,it is of fundamental importance to identify the quality level of care provided,through tools that are able to supply quantitative assessments that can be compared.
Methods: During the first phase,a qualitative survey was carried out by focus groups (FG) for caregivers of deceased patients. During the second phase,a questionnaire (Q) was created by studying the domains identified by the FG according to the importance that was assigned to each domain by those that use the service. Q was submitted to caregivers that participated in the FG during a second encounter:observations regarding this tool were gathered. The Q which has been modified, is being sent by mail to all caregivers of deceased patients, throughout the entire PT, in the first six months of 2008.
Discussion: The following are the main topics that resulted from the analysis: Accessibility, invasiveness of the service, symptom control, continuity-management of crisis, the family's care load, communication, support, attention, dealing with the death of a loved one. The questionnaire, which is currently being submitted, is able to objectify hypothetical differences regarding the quality of care provided, in light of the known organizational and care aspects that are diverse amongst each other.
Conclusion: The FG identified the topics to be investigated through the Q, using methods accepted by those that use this service. The results regarding the comparison of the Q will be available by end 2008.

PE 2.S209

Family taking care of dying relative

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The task for palliative care nurse is to teach relatives to use effective coping strategies such as information search, social support and problem solution.
Aim: To find out how family and significant others perceive this strain situation and what coping strategies in care of terminally ill relative they use.
Methods: We used standardized questionnaire Coping Strategies Inventory. The questionnaire consists of two parts. First part interprets relations - how the respondents have awarded strain situation with emphasis on solvability - insolvability, suggestibility - non suggestibility, caused - uncaused, acquaintanceship and nameless situation. The second part of questionnaire is constructed of 72 items - the statements arranged according to eight primary factors. Every coping strategy is represented by 9 items which are evaluated on Likert type scale from 1 to 5.
Results: Based on the analyses of data obtained we have found out that family members mostly use reception coping strategies oriented on emotions (strategy of social support) and reception problem - solving strategies (cognitive rescheduling strategy, problem solution strategy). Women taking care of dying relatives use more coping strategies oriented on emotions than men.
Conclusion: The members of palliative interdisciplinary team should concentrate on identification of family members and significant others´ problems in the process of preparation for loss and the ways of managing and coping the situation.

PE 2.S210

Emotional overload (caregiver burden) in our caregivers

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Aim: Informal caregivers play a highly important role in today's society.In Palliative Care it is considered that the unit to be treated consists of the patient and the family he or she lives with and who give the patient care.Our objetive is to Know the characteristics of the patient's main caregivers in our Home Hospitalization Unit.
Methods: Descriptive cross-sectional study through interviews of both the patients and their caregivers.Each patient's socio-demographic variables,diagnosis,current treatment,degree of functionality were recorded.The caregivers' sociodemographic data were collected and they were asked to indicate the tie binding them to the patient,the time thus far devoted to caring for the patient,the types of care they gave.They were administered the Zarit questionnaire.
Results: Of the 36 patients 11.8% of the patients did not have a main caregiver(all the members of this group were women), in16.7% of the patients had a purely professional link with their caregivers. 61.8%of the caregivers were women,major differences were noted crossing the patients' and the caregivers' genders: 100% of the male patients were looked after by women, while 38.8% of the women were treated by women (p = 0.01). The level of satisfaction with their work as caregivers and the caregiver burden level (Zarit) were the same when the link with the patient was a family relationship as when it was professional.
We found statistically significant differences (p = 0.04) only when we analysed the Zarit questionnaire with the stratified Barthel Index.
Conclusions:
1. Our caregivers are satisfied with the work they do
2. The caretaker role still falls mainly to wome
3. Caregiver burden is associated with a higher level of patient dependency
4. We must exert an influence on the caregiver and patient as a unit in order to avoid family burnout or abandonment and to enable the patient to remain in his or her usual environment.

PE 2.S211

It's difficult for the volunteer his activity in a palliative care unit?

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Aim: Volunteers must be part of interdisciplinary teams of PC. Its role is to accompany and support to patientes and their families at the end of life, with risk of emotional or spiritual suffering. That´s why we want to know:
- The difficulties of volunteering in the PCU.
- The influence of age, sex, school level and experience as a volunteer in the perception of difficulty.
Method:
- Descriptive qualitative study.

- Self-administered questionnaire with 24 questions.
- Population: Volunteers for Palliative Care of the Orden Hospitalaria de San Juan de Dios.
- Statistical analysis of results with the program SPSS 11.5.

Results:
Men (N=13):
Age (range): 58.69 years (37-74)
School Level: Primary 25%, Secondary 66%, University 8%
Experience in PC (years): <1: 0; 1-3: 53.8%; 3-5: 0;> 5: 7.6%, NA: 38.4%
Situations of minimal difficulty:
- To Support to family very tired: 1.61
- To Introduce yourself and family when the patient enters in the PCU: 1.69
Situations of maximum difficulty:
- To intervene properly when there is a pact of silence: 3.09
- To communicate with nervous or angry patient's relatives: 3.0
Women (N=32):
Age (range): 53.5 years (37-77)
School Level: Primary 35.5%, Secondary 35.5%, University 29%
Experience in PC (years): <1: 6.25%; 1-3: 25%; 3-5: 12.5;> 5: 31.25%, NA: 25%
Situations of minimal difficulty:
- To iIntroduce yourself and family when the patient enters in the PCU: 1.34
Situations of maximum difficulty:
- To answer difficcult questions: 2.78
- Intervene properly when there is a pact of silence: 2.75.

Conclusions: The profile of the PC volunteer in our sample is a woman of 54 years, with secondary studies and with a time of 5 years experience.
The level of difficulty of the daily task is lower for women volunteers (2.17) than for men (2.27).
The time of experience in CP is the main factor influencing on level of difficulty perceived by the volunteers.

PE 2.S212

Occupational roles performance of the formal caregivers in a palliative care service

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During the last decade, the role of the formal caregivers has been increased in the context of the health assistance. The caregiver is also affected by the patient and the family's suffering because, upon taking on this role, there may be losses in the previously occupational roles, resulting from the physical and emotional overloading of his work.
Aims: To introduce the occupational performance pattern of the formal caregivers of a Palliative Care service; to check if there are losses and how they affect the occupational roles performed by those caregivers.
Methodology: A quantitative study was chosen throw the application of the Brazilian version of the Role Checklist, which evaluates the perception of their participation in ten occupational roles (in the past, in the present and planned for the future) and the values attributed to them. Thirty-five caregivers who were working in this service between the period of September 2007 and October 2008 participated in this survey. For data analysis, loss was the basis for the role performed in the past, not performed in the present and planned for the future.
Results: Among the ten occupational roles analyzed - student, worker, volunteer, caregiver, home maintainer, friend, family member, religious participant, hobbyist/amateur and participant in organizations - there could be seen a great loss related to the student (69%) and religious participant (40%) in disregard of the worker and family member which didn't show any losses. The caregivers showed an absent participation in the participant in organizations role. According to the role values analysis, the caregivers gave a major importance to the student (97%), worker (97%), family member (100%) and religious participant (69%).
Conclusion: After analyzing the collected data, it was possible to conclude that the caregivers suffered a great loss in roles considered of major importance and so the Palliative Care services must develop strategies to support this group.

PE 2.S213

Exploring the role of religious beliefs amongst the family caregivers of terminally ill cancer patients: A qualitative approach

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Introduction: The topic of spiritual and religious believes appears to be gaining recognition as a focus of research in cancer and supportive care. However, the subject of religious faith and the possible influence of religious and spiritual beliefs amongst Greek Family caregivers of terminally ill cancer patients has been explored.
Aims and objectives: To develop an understanding concerning the role of religious beliefs amongst family caregivers of terminally ill cancer patients. To explore the religious beliefs amongst Greek family caregivers of terminally ill cancer patients and role of religious beliefs when dealing with the terminal stage of their relatives' lives.
Design: A qualitative study using a hermeneutic phenomenological methodology.
Sample: A purposive sample of Greek family caregivers of terminally ill cancer patients.
Methods of data collection: Semi- structured interviews.
Results: Family caregivers derived strength, comfort, hope and meaning from religion. Religion was an integral part of their lives, and not a set of beliefs detached from everyday life and experience. Also the majority of caregivers indicated that their beliefs have not changed because of the illness or the deterioration of their loved ones' condition.
Conclusion: Religion was an integral part of individuals life's. A religious framework was used to attach meaning to participants' experience and maintain a sense of hope. Religious beliefs are important coping strategies for family caregivers, and emphasis should be given by the health professionals to the religious and spiritual concerns of caregivers.

PE 2.S214

Family resilience: A study of the lived experiences of family members of people with oncological terminal illness, while hospitalized

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Aim: To describe some dimensions of resilience in the family members of patients with an oncological illness in terminal phase, while hospitalized.
Study design and methods: This study was carried out at a ward of a central hospital. Here we can find what is commonly designated as "a reference visitor", a visitor chosen by the patient, who will accompany him/her daily from 9 a.m. to 8 p.m., assisting in the process of necessary cares of the patient, like feeding, hygiene, and most importantly, emotional support, accompanying him/her until the moment of death. A phenomenological hermeneutic study was made, according to the Max van Manen approach, which included the participation of four reference visitors, which selection was made by rational selection.
Findings: Some themes which emerged and interconnected in a complex and systematic way, allowing access to the essence of the phenomenon and to formulate a diagram to understand the phenomenon that is being studied: resilience; hospital context; taking care of another; Communication processes; Organization patterns; Beliefs sistems and suffering.
Conclusion and implications: The carrying out of this investigation brought a new character to the present moment in which we are, in so far as by studying the experiences of family members of patients with oncological illness in terminal phase, who accompany their patient in a hospital unit, I tried to study not only their experience in dealing with pain but mainly their strengths, their resilience capacities. Concerning resilience development and promotion, it carries important social implications, given that the death experience in a family treated in a healthy and supportive way reduces the morbidity risks and family, professional and social consequences.

PE 2.S215

Children in households of palliative patients: Danger of life by unsecured medication

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Most palliative patients would like to spend the end of their lives at home. In Germany this wish is at present supported by a law that guarantees professional out-patient palliative care. The treatment of serious symptoms requires various strong medications which, if taken accidentally by a child, could cause fatal poisoning. The aim of the research is to find out how many children live in or come to visit households with palliative patients.
Method: We analyse the anonymised data of patients at home-based palliative care during 3rd quarter 2008. Within the framework of giving information about safety measures the age of the youngest child living in the household or having visited it during the past few weeks was taken into account.
Results: 45 complete sets of patients' data were evaluated. On average the patients were 72 years old, 84% of them had a basic malignant illness, 88% were treated with strong opiates. In 64% of the households were children under 10 or children who had come on visits. The average age of these children was 4 years.
Discussion: Due to demographic developments and political efforts made in that field a definite increase of the number of palliative patients being treated at home is to be expected. Most of them will be treated with opiates WHO level III and in addition to those other medication which is potentially fatal for children will be used. Those patients looked after by us were visited by children, the youngest of whom was in general a toddler (Median 4).
Insufficiently safeguarded drugs mean a real danger especially for very small children. Most opiates are therefore categorised as "one pill can kill".
In Bochum we had a case of Oxazepam poisoning which ended happily - but an opiate would have ended fatally for a two year old boy.
Conclusion: Within the framework of out-patient palliative care it is absolutely necessary to inform the households about the safe storage of potentially fatal medication.

PE 2.S217

A legacy for life pre "Dignity Therapy"

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Background: In 1982, while Dr Margaret Dunn was dying of cancer she recorded taped messages to her 2 year old son. During this time and after her death, her six siblings, who were spread over four continents, communicated through letters. These messages and letters, along with recent emails from the now adult son have been collated and restudied.
Aims: To draw attention to the themes that emerge from a united family who experienced bereavement. To explore the current resonance of a legacy document created 27 years ago. To consider how much of what is now called "Dignity Therapy" is intuitive and how much it can be caught, taught and developed into good practice.
Methods: Using a thematic approach, the final words, letters and emails were analysed to identify the underlying messages relating to mind, body and spirit. A careful hindsight review of how the family developed was conducted. This explored how much they expected the death to impact on them and what the actual effects were.
Conclusions: No member of the family offered a negative response to their experience. The approach proved to be a catalyst for open, honest communication during future experiences relating to life and death. Many members of the family including the next generation are involved in empowering others towards emotional intelligence either professionally or voluntarily. An individual legacy document can make a profound impact across several generations.

PE 2.S219

Reasons to work in palliative care: An empirical study among Indian palliative-care nurses and physicians

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Aims: Religion played an important role in the early years of the modern palliative care movement. We wanted to know what motivates contemporary Indian physicians and nurses to devote themselves to palliative care. We were particularly interested to assess to what extent religion motivates them.
Methods: We opted for an explorative research design based on 27 semi-structured face-to-face interviews following Grounded-Theory methodology (Glaser & Strauss). 14 physicians and 13 nurses were interviewed from May to September 2008. At the time of the interview all respondents were working in different palliative care programmes in New Delhi (palliative-care ward, home care, hospice, pain clinic).
Results: Most respondents started working in palliative care accidentally: they came to know about palliative care after responding to a vacancy in a palliative-care programme (11 respondents), or after starting a specialisation in anaesthesiology (7 respondents). Working in palliative care is experienced as a very satisfying job, especially because palliative care offers holistic treatment, and the physicians and nurses feel their work is appreciated by the patients and their relatives. Two physicians and five nurses explicitly gave a religious interpretation to their work. Three respondents told that their work in palliative care is a service to God, either because God dwells in the patient, or because God particularly loves those who suffer. Two respondents saw themselves as an instrument of God's grace. Questions regarding religious issues showed that most respondents regularly pray, meditate, or visit a temple.
Conclusions: Professional gratification and personal satisfaction seem to be more important stimulating factors to work in palliative care. Nevertheless, religion helps several respondents to give meaning to their efforts in palliative care.
Funds: Faculty of Theology (KUL) & VLIR-UOS

PE 2.S220

Barriers to caring for terminally Ill patients in the home: A cross-country comparison

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Aim: This qualitative study aims to compare a sample of U.S. and Hungarian physicians' perceptions of obstacles to caring for terminally ill patients in the home. We hypothesize that physicians' perceptions will differ based on cultural differences and accessibility of hospice programming.
Methods: Purposive samples of physicians from Hungary and the U.S. were surveyed. A voluntary, self-administered survey and cover letter were mailed to all practicing family physicians (339) in Baranya County, Hungary. The survey was written in English, translated into Hungarian, and pre-tested on Hungarian faculty physicians. After similar vetting in the U.S., the survey and cover letter were mailed to 300 family practitioners and general internists in Summit County, Ohio in the U.S. The authors independently content analyzed responses to an open-ended question and later convened to compare results and arrive at consensus.
Results: Comparing percentage of responses, the most common barriers reported by Hungarian physicians were: Demands of 24 hour care on the family - 34.4%; Treatment related obstacles - 12.98%; and Program related obstacles - 12.6%. U.S. physicians responded with a less clearly defined pattern: Inadequate support for families - 14.8%; Demands of 24 hour care on the family - 14.8%; and Families' lack of professional knowledge about the care of terminally ill patients - 9.6%. Additional layers of barriers for U.S. and Hungarian physicians are defined and presented in more detail.
Conclusion: Family burden and system related obstacles were more consistently identified by Hungarian physicians. U.S. physicians gave more diverse responses, primarily focusing on the family. These distinctions reflect the social, cultural, and health care system differences in which U.S. and Hungarian physicians provide end of life care. The U.S. Fulbright Program and the Summa Foundation funded this study.

PE 2.S221

Everyday life of people with advanced cancer: Activity, time, location and experience

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Today increasing numbers of people with advanced cancer live at home for longer and longer periods of time towards the end of life. Advanced cancer impacts the individuals´ capacity to engage in everyday activities. For example bodily deterioration may lead to a variety of losses from basic functional skills to the ability to maintain social roles. While there is an awareness of the problems an advanced cancer may cause in everyday life, little is known about what people actually do under such circumstances. More specifically, what activities they engage in and how these are experienced. If palliative care is to support people with advanced cancer in living at home for as long as possible, there is a need to assemble specific knowledge about the activities that occupy the daily life of people with advanced cancer and about the ways in which activities are meaningful to them.
The aim of this study was to describe and explore the everyday activities of people with advanced cancer in relation to time, location, social engagement and experience. Forty-five adult participants were sampled from an oncological out-patient unit representing the three cancer diagnosis, lung- colon- and breast cancer. Data was collected by a Time Geographical Method including diaries and interviews. The data were organized by a specific software programme producing time-use graphs and all data were analyzed with a constant comparative method. The results showed that the participants´ days were spent mostly at home, dominated by self-care and leisure with limited social engagement. A central feature of activity rhythms were identified to be composed of routine and novel activities closely related to the participants experiences of satisfaction with daily life. For palliative care services the results suggests a need for developing services to support people with advanced cancer in creating and maintaining personal rhythms.

PE 2.S222

Improving palliative care knowledge and awareness through the medium of photography

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Aim: As the palliative care effort increases around the world, there is a growing need to explore how best it can be documented and the role that documentation may play in advocating for policy and service improvement. In recent years there has been a modest but important increase in the availability of visual materials - including still photography and film - that "face" the dying process with sensitivity and understanding and explore the role of the palliative care approach.
Results: We discuss the potential use of photographs to impact on the attitudes and beliefs of policy makers and funders, healthcare professionals, grassroots organizations, families and patients themselves about various aspects of delivering care near the end of life. A set of photographs by Cathy Greenblat, which is on exhibit at the conference, will be used to explore this. The photographs come from institution based and home care programs in the USA, France, Japan, and India. They illustrate humanity and compassion in the delivery of palliative care, showing clearly what is meant by maintaining dignity while delivering care to patients and those close to them.
Conclusions: The sociological perspective teaches us that being defeated by the ravages of age and illness is not solely the result of biological degeneration, but also of the failure of social and cultural institutions. Even under the most debilitating conditions, given the right support, it is possible to sustain the dignity of the individual and members of his or her surrounding world. Photography has much to teach us in this regard. We urge that photographs such as these can help people to understand and adopt such a perspective - and should be more widely utilized in the promotion of palliative care.

PE 2.S223

The interdisciplinary team: Themes in care

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Aims: Research is limited about the Palliative Medicine Interdisciplinary Team (IDT). Challenges include psychosocial care, team structure and efficiency. An 8 week observation study of a daily IDT meeting was conducted to identify care themes.
Methods: Our IDT comprises physicians, nurses, social worker, music therapist, and discharge case manager for a 23 bed acute care palliative medicine unit (ACPMU). Weekly observation for themes was done. Hierarchical cluster analysis identified theme patterns.
Results: 9 major themes were derived from 59 patients:
1) varied interdisciplinary viewpoints
2) difficult anti-tumor treatment transitions
3) caregiver conflict
4) changing care goals
5) discharge delays
6) psychosocial assessment and family conference needed to clarify discharge plan
7) service conflict
8) inadequate discharge resources and
9) no spokesperson.
The analysis identified 3 theme clusters in order of strength: Clinical Operations (Themes 5&7), Psychosocial (Themes 6&8&9), Goals of Care (Themes 3&4). Themes 1& 2 were most frequent but did not cluster. The goals of care cluster identified caregiver distress which caused aversion or diversion of communication when transitioning from palliative chemotherapy to palliation without chemotherapy. The clinical operations cluster involved timely assessment and interventions. The psychosocial cluster linked spokesperson, family conference, assessment and family- caregiver support to plan of care and discharge resources.
Conclusions: Clusters are clinically relevant domains and can help classify IDT meeting content and process. Functional team members recognize care needs, report concerns, and collaborate in proactive patient care. Palliative medicine is an entry point for care transition. The IDT manages barriers and potential points of conflict. Themes identified domains that need to be addressed for effective hospital discharge. The study identified themes for quality improvements in the IDT.

PE 2.S224

Enteral feeding for older people with advanced dementia: Findings from a Cochrane systematic review

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Background: The ageing global population is increasing the prevalence of dementia. In advanced dementia poor nutrition and the use of enteral feeding are common. This is not without controversy; the benefits are unclear, as are the outcomes to measure i.e. length of survival versus quality of life (QOL). Potential harms include aspiration, gastrointestinal disturbance, prolonging psychological distress and physical restraint to prevent extubation. The ethics of not providing nutritional support are controversial.
Aim: To evaluate outcome of enteral nutrition for older people with advanced dementia.
Method: 7 citation databases, including MEDLINE were searched. Randomised controlled trials (RCTs), controlled clinical trials, controlled before and after and interrupted time-series studies were included. Observational studies were included in the absence of controlled evaluations. Meta-analysis was considered for RCTs with comparable characteristics.
Results: No controlled trials were found. 6 observational studies were identified. In 5 there was no

clear evidence that survival improved. None examined impact on QOL, behavioural and psychiatric symptoms of dementia (BPSD) or activities of daily living. Nutritional parameters were measured; one study found no impact on weight, BMI, albumin or haemoglobin, the other a limited effect on weight gain. One study found an increased risk of pressure sores and one a decreased risk. Two studies commented on adverse events. These were more common in enteral feeding: they included abdominal abscess, pneumonia and physical restraints.
Conclusion: There is no evidence of benefit in terms of survival, nutritional parameters or pressure sores from enteral feeding in older people with advanced dementia. Studies have not assessed the impact on QOL, function or BPSD. Methodologically and ethically randomised trials are challenging, however it is important to find robust ways to evaluate the impact of enteral feeding.

PE 2.S225

Attitudes of specialist palliative care consultants to the use of interventions in the care of motor neurone disease

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Background: The use of nutritional enteral feeding, using a percutaneous endoscopic gastrostomy (PEG) or percutaneous radiological gastrostomy (PRG) and ventilatory support, using non-invasive ventilation (NIV), is increasing in the care of people with MND/ALS in the UK. However the use of the techniques varies greatly across the UK and it assumed that this may be due to differing attitudes towards these interventions from the health professionals providing care.
Objectives: The study aims to ascertain the attitudes towards, and the discussions held with, patients under the care of specialist palliative care services, who may develop symptoms which could be helped by gastrostomy insertion or NIV.
Methods: Consultants in palliative medicine in hospices providing specialist palliative care for people with MND/ALS were contacted by telephone by the researchers, who are also consultants in palliative medicine. A questionnaire had been developed and the consultants were asked questions about their attitudes and use of PEG and NIV in a structured format.
Results: The results show that there are differences in the attitudes of consultants in the way that these areas of care are discussed. These attitudes are changing and there was the expression for the need of careful multidisciplinary discussion before there is discussion with the patient and family.
Discussion: The use of theses interventions are important in the provision of palliative care for people with MND/ALS - the use of gastrostomy can be very helpful in improving the quality of life and NIV can both improve quality and length of life. There seem to be a great variation in the attitudes of specialist palliative care doctors towards these interventions. The results of this study will help inform the best ways of helping doctors and other health care professionals discuss these issues in greater depth and enable people with MND/ALS to take informed decisions about their care.

PE 2.S226

Palliative care for all: Challenges and implementation

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Aim: Physical and psychological symptom burdens of many life-limiting, non-malignant diseases compare to those of cancer. Palliative care has a role in the care pathway of people with non-malignant conditions, but traditionally specialist palliative care (SPC) services have focussed on people with cancer. The Irish Hospice Foundation (IHF) and the Health Service Executive (HSE) undertook a joint study in 2007/08 on how specialist and non-specialist palliative care could extend to people with non-malignant conditions, with an initial focus on COPD, dementia and heart failure.
Methods: Methodology was wide-ranging literature review and consultation through collaborative working groups, guided by a national steering group.
Results: The study's report "Palliative Care for All" outlines findings and recommendations on extending access to these patient populations. Challenges identified included:
- uncertain disease trajectories;
- establishing clarity on the role of palliative care in non-malignancy;
- inconsistent access to SPC;
- lack of comprehensive chronic disease-management services in Ireland and
- developing collaborative approaches between disease-specific specialists, SPC, primary care and older persons' services for those with advanced life-limiting conditions.

Conclusion: The implementation of the report's recommendations includes:
- Appointment of clinical facilitators to pilot and develop service models integrating palliative care within disease-specific frameworks;
- Generating disease-specific palliative care information material on non-malignant conditions including COPD, heart failure, dementia, chronic kidney disease, scleroderma, pulmonary fibrosis, cystic fibrosis and multiple sclerosis;
- Standardised eligibility and discharge criteria for access to SPC;
- Advocating and promoting awareness of palliative care for non-malignant diseases through production and dissemination of educational materials based on the study's findings.

PE 2.S227

Systematic screening of symptoms, cognition and quality of life issues in heart failure patients - Collaboration: Pilot project between cardiology and palliative medicine

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Congestive heart failure remains one of the leading cause of death in the Western world. Heart failure (HF) is a chronic, inexorable debilitating illness with increasing prevalence in the elderly population. Mortality rates for HF patients are as high as 30% in the first year after diagnosis and the need for emergency department visits or hospitalizations is staggering. With an aging population, better cardiac therapies turn an acute disease into a chronic disease (e.g. fibrinolytic and primary percutaneous intervention). Coupled with the other chronic illness associated with age such as dementia, renal disease etc, the care of patients with HF is becoming increasingly complicated and results in significant symptom burden.
HF patients report high symptom burden, which includes pain, anxiety, depression and shortness of breath. These rates are similar to patients with cancer and Acquired Immune Deficiency Syndrome but have not been addressed well in the literature. At the University of Alberta Hospital, a pilot project between Cardiology and Palliative Medicine has been set up to help better manage the refractory cardiac symptoms for heart failure patients. It is called the Heart Function Clinic-Palliative Care Clinic (HFC-PCC).
This is made up multi-disciplinary team with a Cardiologist, Palliative Care physician, 2 nurse specialists (1 Palliative Care nurse and 1 HF nurse), a pharmacist and a dietician.
Using standard palliative care tools including the Edmonton Symptom Assessment Scale (ESAS), Palliative Performance scale (PPS), Mini-mental state examination (MMSE), New York Heart Association Class (NYHA) and KC Cardiomyopathy Questionnaire (KCCQ), we would have screened approximately 300 patients with the ESAS, MMSE, KCCQ, NYHA and PPS by 31 Jan09.
This pilot project is the first in heart failure to assess and correlate the symptom burden, functional status, cognition and quality of life issues of these patients.

PE 2.S228

A collaborative approach to the development of a working model for end of life care for patients with dementia

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Background: Evidence to date shows few examples of teamworking in the fields of old age psychiatry and specialist paliative care. Dementia due to it´s long disease trajectory is particularly difficult to plan for end of life care. A multi professional group from both discipines in Northwest England utilising National end of life tools developed a working model of end of life care for patienys with advanced dementia to be utilised in Care homes.
Methodology: A multi-professional group of professionals from both acute and community sevices was formed to identify a joint model of care that could be delivered to patients with end stage dementia in care homes.A workshop format was adopted with representatives from old age psychiatry, palliative care,speech alnd langauge therapy, dietetics, primary and social care and carer societies. A pathway was developed to be used along side symptom control, referral guidelines and guidance regarding use of end of life tools such as advanced care plans and Liverpool care of dying pathway.
Two care homes in locality were selected who were already using Gold standards framework and a programme of education around topics of symptom control, end of life communication issues was delivered.
Results: Evaluation is planned comparing care delivered in pilot nursing homes with standard care, looking at staff satisfaction and confidence around managing end of life care, the number of transfers to hospital of patients in terminal stages and numbers of deaths in care home.
Conclusion: It is hoped that this model of joint working will improve team working and be replicable in hospital and home settings across the locality. Further joint educational events including carer workshops are already planned.

PE 2.S229

A retrospective review comparing malignant and non-malignant referrals to a hospital-based palliative care service

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Aims: Palliative Care teams are increasingly receiving referrals for patients with non-malignant conditions. This study was performed to examine the nature of referrals to a hospital-based palliative care team(PCT) and the outcomes and to examine the use of medications and level of active interventions at the time of death, looking for any differences between malignant and non-malignant referrals.
Methods: Referral statistics for patients seen by the PCT were examined, including patient demographics and the outcome for each patient. A retrospective chart review was performed for thirty consecutive malignant referrals and thirty consecutive non-malignant referrals, who died in the same referral episode. Interval between referral and death was recorded, as well as the use of medications for symptom control. Interventions such as phlebotomy, IV antibiotics and artificial feeding were recorded.
Results: Of 343 new inpatient referrals in 2007, 25% had non-malignant disease. 71% of the non-malignant patients died during the first referral episode, while 38% of the malignant referrals went home. The median interval between referral and death was 13 days in the non-malignant group and 25 days in the malignant group. Prevalence of opioid use was similar in both groups, but higher doses were used in the malignant group. Similar levels of active intervention prior to death were found between the two groups.
Conclusion: 25% of patients seen by this service have non-malignant disease. Our figures indicate that these patients are referred at a more advanced stage in their illness and are more likely to die during the first referral episode. Our review indicates that cancer patients receive higher doses of opioids than non-cancer patients. In both groups many patients received active interventions within 24 hours of death, though this did not appear to differ significantly between the two groups.

PE 2.S230

Supportive and palliative care in End Stage Heart Failure (ESHF) patients: A literature review

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Heart failure is a major cause of morbidity and mortality in the Western world and its prevalence may

increase with the ageing population. Many end stage heart failure (ESHF) patients are thought to have palliative needs, but it is necessary to collate existing knowledge by reviewing the literature systematically. This review aims to describe:
a) the impact of ESHF on patients and close persons;
b) the perceptions of health professionals caring for ESHF patients;
c) health care provision for ESHF patients and close persons.
A systematic literature search using Medline, Embase, CINAHL, PsycINFO and AMED identified 44 relevant studies. The main findings were: symptoms of ESHF, mainly fatigue and breathlessness, have a major impact on the daily lives of both patients and close persons; patients have poor understanding of their illness and few opportunities to discuss their disease with healthcare professionals; healthcare professionals lack confidence in diagnosing ESHF and communicating a poor prognosis to patients, resulting in barriers to the provision of good quality coordinated care. Many specialist palliative care teams have good collaborative links with heart failure services and primary care, but work to evaluate the impact of health service provision for ESHF patients and close persons has been limited. There are good quality studies looking at experiences and needs of ESHF patients and close persons, but more research is needed to evaluate the effectiveness of health service interventions for ESHF patients and close persons, and their feasibility and acceptability to health care professionals.

PE 2.S231

The development of a new specialist palliative care service for people severely affected by neurodegenerative conditions in Italy

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Aims: This study shows the development of the specialist palliative care service (SPC) in Turin, Italy, with increasing involvement in the care of people with neurodegenerative conditions.
Methods: A 3 year programme has been developed: a literature review; a qualitative assessment and a randomized controlled study of the new service. 22 patients severely affected by amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), Parkinson's disease (PD) and related disorders (PDRD) and their main carers were interviewed and there were 3 focus groups with neurologists and other professionals involved in the care of these patients.
A randomised trial of care is being undertaken to evaluate the impact of the new service considering the palliative care outcomes of people severely affected by ALS, MS, PD and PDRD . 50 patients, divided in the different diagnosis, are being randomized to two groups: a fast track group (FT) will receive the service immediately while a standard track group (ST) will have to wait for a 4 month period of time. Comparison the results of the stanardised tests will allow the effectiveness of the new service to be evaluated.
Results: The qualitative interviews and groups confirmed the high burden of palliative care needs in our sample and the need of a specific education process for our team members.The need for specific training to educate the professionals was identified. Data analysis of the RCT will start at the end of the study period and preliminary results will be available in 2009.
Conclusions: People severely affected by neurodegenerative conditions suffer of a high burden of unmet palliative care needs. Through education of the professionals involved and the development of the new servicie it is hoped that the care provided will improve the quality of life and care for this patient group and their families. The approach taken should enable a clear assessment of this development.

PE 2.S232

Palliative care needs of people severely affected by neurodegenerative conditions: The views of the professional carers

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Aims: Patients severely affected by neurodegenerative conditions experience many symptoms, as well as spiritual and psycho-social distress. The views of professional carers involved in the care of this patient group were ascertained and compared to the issues identified by the patients themselves.
Methods: During the development of a new palliative care service a qualitative assessment of patients´ needs has been compared to the results from 3 focus groups, involving 8 neurologists, 1 rehabilitation specialist (expert in artificial ventilation), 1 physiotherapist and 1 speech and language therapist (all working in department for the care of people with motor neurone disease, multiple sclerosis or Parkinson's disease and parkinsonisms). These professionals were asked to give their opinion about the main unmet needs of this population.
Results: A content analysis of the groups highlights the participants awareness about the high burden of physical symptoms of their patients, such as uncontrolled pain and breathlessness, as well as the psychosocial issues and the spiritual dilemmas. There was little knowledge of pain therapy and a low use of opioids. All participants where supportive of the development of a new palliative care service aimed at improving patients quality of life, supporting caregivers, aiding end of life choices and issues and reducing inappropriate hospital admissions and overtreatment. Respite hospice admission was felt to be fundamental to sustain care at home, by giving providing support for families.
Conclusions: Professional carers are aware of the needs of patients but are less aware of the role of palliative care and the use of medication, and particulalry opioids. They do see the need for networking among hospital services, palliative care and primary medicine and care pathways may be developed to aid the assment and palliative care of this patient group.

PE 2.S233

A qualitative assessment of the physical symptoms of people severely affected by neurodegenerative conditions: The physical symptoms receiving palliative care

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Aims: People severely affected by neurodegenerative conditions experience many symptoms and other psychosocial and spiritual problems, similar to those of cancer patients. As a part of a PhD program in palliative care at the University of Kent a project has been developed to assess people severely affected by Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis (MS), Parkinson´s Disease (PD), Multisystems Atrophy (MSA) and related disorders and to provide and evaluate, a new specialist palliative care service in Turin area.
Methods: In order to assess palliative care needs of these population living in Turin area 22 in depth interviews have been conducted with patients and their carers - 9 ALS, 7 MS, 5 PD and 1 MSA. Content analysis of the transcripts verbatim has been performed, looking at the physical symptoms experienced in this patient group.
Results: Out of the 22 interviewed patients 100% had severe impairment of movement: most were on a wheelchair, some were bedbound. 95% had swallowing troubles or choking with food episodes and nutritional related issues. 82% reported to be in pain, 82% dyspnoea or respiratory problems, 73% bowel problems, 64% speech impairment, 64% depression, anxiety or insomnia, 59% urinary problems, 45% drooling and other mouth issues, 45% skin troubles, 60% other symptoms such as recurrent fevers, blurred vision.
Conclusions: This initial study confirms the high prevalence of physical uncontrolled symptoms in this population. A specialist palliative care service is being developed to help meet many of these needs, with a specific domiciliary and hospice service in the Turin area.

PE 2.S234

Prevalence of symptoms in patients with end-stage heart disease

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The heart disease is a progressive illness associated with high morbility, mortality and functional deterioration. Like in other non-oncological chronic diseases, there are few patients profiting from palliative care programs.
Aims: To determine the prevalence of symptoms in patients with end-stage heart disease included in a palliative care program.
Method: Descriptive retrospective study. The data from patients with end-stage heart disease included in support palliative care programs in a period of five years were collected. The inclusion criteria were those recommended by the National Hospice Organization. The symptoms were assessed using the Edmonton Symptom Assessment Scale (ESAS). Others data were registered: the functional situation using the Barthel Index (IB), the Karnofsky Index (IK), the place of death, and the permanence time in the palliative care program.
Results: A total of 1921 terminally ill patients were included in the program. 108 (5.6%) were non-oncological, among them 18 (16.6%) were patients with end-stage heart disease. The average age was 76 years (section 58-90). 94.4% showed a IK lower tan 50 and 77.7% presented a serious or severe functional deterioration (IB <60). The referred symptoms were: asthenia (83%), dyspnea (66%), xerostomy (61%), anorexia (55%), constipation (38 %), insomnia (38%), anxiety (38%), depressed mood (38%), pain (27%), nausea (16%), and cough (11%). The average number of symptoms by patient was 5 (section 1- 10). Of 18 patients included, 17 have died. The average stay at the program was 70 days (section 1-660), dying at home 10 patients (55.5%).
Conclusion: This study suggest that patients with end-stage heart disease have great symptoms control needs, similar to those of terminal patients with cancer thus being able of benefit from palliative care. The disease´s increasing prevalence underscore the need to integrate this model of care with the acute care approach that has dominated heart failure treatment.

PE 2.S235

What are the palliative care needs of adults newly diagnosed with HIV in Uganda? A multicentre study

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Background: World Health Organisation guidance states that palliative care should be provided from diagnosis of HIV until death, but there is little evidence of the specific needs of people at HIV diagnosis. Understanding the nature and prevalence of needs is essential to delivering appropriate care.
Aim: To determine the palliative care needs of adults in Uganda in the two weeks following HIV diagnosis.
Methods: A prospective longitudinal study in Uganda recruited adults attending six HIV care facilities either with a new diagnosis, or a new presenting problem. Participants completed the APCA African POS, MOS-HIV and a Client Services Receipt Inventory at monthly intervals for three months, with additional demographic and clinical details collected at baseline. Cross-sectional baseline data for newly diagnosed people are presented here.
Results: In total 187 people were recruited within two weeks of HIV diagnosis, 108 (58%) women and 79 men. The mean age was 31 for women and 36 for men, with a range from 18 to 55. 75 (40%) were diagnosed on the day of recruitment to the study. Only 32 participants (17%) were accompanied by a carer. The POS responses showed that in the three days prior to baseline, 22% of participants were in severe, very severe or overwhelming pain, and 17% experienced other symptoms to the same intensity. 15% never felt at peace, 27% had been unable to share how they felt with anybody, and 23% had been worried all, most or a lot of the time. 11% never, or not very often, found life worthwhile.
Conclusion: At the time of diagnosis with HIV, people in Uganda experience physical, psychological, spiritual and social palliative care needs which must be addressed as soon as possible. These are the first data to demonstrate the nature and intensity of palliative care need immediately following HIV diagnosis.
Funding source: President´s Emergency Plan for AIDS Relief, via MEASURE Evaluation.

PE 2.S237

Palliative care for non-cancer patients in specialised palliative care in Germany - Data from the German Hospice and Palliative Care Evaluation (HOPE) 2002-2005

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Aim: In order to learn more about non-cancer patients in specialised inpatient palliative care in Germany, patient data from the Hospice and Palliative Care Evaluation (HOPE) was analysed.
Methods: Since 1999, a three months census is conducted annually in the majority of German palliative care units. Pooled data from 2002-2005 were tested for differences (χ?) between non-cancer and cancer patients concerning symptoms/problems, functional status and need for nursing care.
Results: Overall 4182 patients were documented. Of these 147 (3.5%) were non-cancer (NC) and 4035 (96.5%) cancer patients (C). In NC the most common group of diagnoses related to the nervous system (29.9%), followed by the circulatory system (20.4%) and the lung (8.8%). The most common single diagnoses were MND and chronic heart failure (8,1% each). NC patients were of lower functional status (ECOG: 3-4 NC 85% / C: 75.3%; p=0.009), suffered more often from moderate to severe dyspnoea (40%; C: 29%; p=0.004), weakness (92,3%; C: 84,5%; p=0.001) and tiredness (75.4%; C: 66.7%; p=0,03) and less from nausea (17.1%; C: 28.9%; p=0.002), vomiting (8.2%; C: 19.4%; p=0,001) or loss of appetite (55.5%; C: 67.9%; p= 0,002). No differences were seen in pain und constipation. Symptoms and problems in the other categories (nursing, psychological) were more frequent for NC patients, especially the need for support in the activities of daily life (90.3%; C: 72.8%; p<0.001) and disorientation/confusion (32.1%; C: 17.2%; p<0.001). Social problems were equally frequent.
Conclusion: Even if palliative care issues of non-cancer patients differ in prevalence to cancer patients the necessity for specialised palliative care is revealed. The overall number of non-cancer patients in specialised inpatient palliative care in Germany is far below compared to what should be expected. Only by resolving this apparent mismatch and addressing the specific needs an adequate provision of care of these patients can be achieved.

PE 2.S238

Specialist palliative care and non-cancer patients: A retrospective review of referrals in the acute hospital setting

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Introduction: Access to specialist palliative care services (SPCS) should be based on need and not disease type. Typically, the majority of patients referred to SPCS have malignant disease.
Aims: This retrospective review was conducted in two acute hospitals to examine referral patterns to the SPCS, with particular reference to patients with non-malignant disease. Each hospital has an established consultant-led SPCS.
Methods: All new non-malignant referrals to the SPCS over a three-month period were included. Data was analysed using excel and SPSS.
Results: The total number of non-cancer referrals to the SPCS was 29/336(8.6%) and their mean age was 79 years of age. Patients had on average 2.3 co-morbidities. Stated reasons for referral' included symptom control 13(45%), and end-of-life care 11(38%). Over half the referrals (56%) came from cardio-respiratory services. Twelve patients (41%) died within 1 day of referral, 8(21%) died within 1 week, and 1(3%) patient died within 1 month. Four patients (14%) were subsequently discharged from the service, 4(14%) were discharged home and one patient (3%) transferred to the SPCS in-patient unit.
Discussion: The overall proportion of non-cancer patients referred to the SPCS is low. We recognise that cancer patients may have multiple co-morbidities, which contribute to their symptom burden and care needs. Nevertheless, referring doctors seem to be less aware of the role of SPCS on the care of patients with non-malignant disease. Referrals are often late and focused on the care of the imminently dying. This referral pattern limits the overall impact of a SPCS in an acute general hospital. Evidently, there is need for more education of hospital based colleagues in the role of SPCS, particularly in the earlier stages of the disease process.

PE 2.S239

Non-cancer and cancer patients in palliative home care - What's the difference?

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Background: Even though most patients receiving palliative care (PC) are cancer patients (CP), the number of non-cancer patients (NCP) having access to PC has been increasing over the last years. As a consequence research should focus on this patient group at an early stage of this process. This study explores the characteristics of outpatient care for NCP, undertaken by the specialised palliative home care service (SPHCS) in Bonn, Germany.
Method: Retrospective analysis of the comprehensive data base of SPHCS, using all patient data sets from 1/2006 to 12/2007. Data of NCP and CP were tested for group differences concerning demographic and epidemiological data, reasons for introducing and finishing of SPHCS as well as place of death using chi square (statistical significance at p<0.05 in all tests).
Results: Inclusion of 456 patients; 424 (93%) CP and 32 (7%) NCP in an advanced stage of their disease. The median age is 70 y (<70 y; NCP 31.1% /, CP 50.2%; p<0.05). No significant differences in the reasons for first SPHCS contact. Place of death (NCP 80%, CP 52.6%, p<0.05 ; n=341) was significantly more often home in NCP than in CP. Discharge out of the SPHCS before death was more frequent in NCP (reason: no longer need for SPHCS; NCP 28.1%, CP 5.9%; p<0.05).
Conclusions: The distribution of NCP and TP of this SPHCS reflects the current situation in Germany in the outpatient sector. The percentage of NCP that finished SPHCS with the reason 'no longer needed' raises the question whether the current range of SPHCS services covers the needs of NCP and if the multiprofessional teams should develop a wider scope of offers, more appropriate for NCP. More detailed documentation of reasons for ending of SPHCS services is recommendable. However, the overall stabilising effect of SPHCS on home care situations is reflected in the comparatively high percentage of NCP that are enabled to stay at home until death.

PE 2.S240

The organisation of palliative care in home - One of the most priority and economically defensible directions of development of the palliative help not oncological patients for Belarus (and the majority of republics of the former CIS)

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Specificity of palliative care in home is the palliative help in a combination to sisterly leaving. And, sisterly leaving at some stages of work with the patient is even dominating. It is a question of rendering of the palliative help not oncological sick, and to ailing and helpless people without guardianship, so-called not mobile patient who make about 5% from the general number of geriatric patients. These people cannot serve themselves for whatever reasons. At the given patients also the medical problems demanding the help, together with the psychology-social and spiritual help, as a rule, take place. On the first visit the command of experts for an estimation on a place, both complexity of a medical problem, and complexity of a psychology-social situation always leaves. Thus, the home visiting service is as though more socialised kind of the help, especially, in relation to elderly, lonely and to socially not protected categories of the population.
Work of our Centre of the palliative help testifies that various categories of patients among which more than 60 % are not oncological patients very require the palliative care.
Among patients of our Centre the basic quantity is made by geriatric patients or the aged people having some of chronic diseases. In this respect the palliative care in home has variety of advantages before the similar help in the conditions of a hospital. First, the volume of the necessary help can appear the patient without change of a house situation. Secondly, the complex of problems medical, psychological, social, and in some cases and spiritual character dares at once. Thirdly, economically effective system of rendering of services in comparison with the same hospice work takes place. Fourthly, the continuity of various services, palliative service, a social service, polyclinic service which by common efforts can supervise a social situation more effectively takes place.

PE 2.S241

Progressive Supranuclear Palsy and Cortico-Basal Degeneration - Atypical parkinsonism disorders with impications for palliative medicine

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Aim: Progressive Supranuclear Palsy (PSP) and Cortico-Basal Degeneration (CBD) are rare diseases with an estimated number of 12.000 people affected in Germany. However, the total number might be even larger since these patients are sometimes diagnosed as Parkinson's disease. Some patients with PSP or CBD respond well to medication at the beginning of the disease but it lasts only for a limited time. Symptom control is an important issue for these patients. Respiratory related deaths are more common in these patients since in Parkinson's patients.
Materials and methods: We report on patients with PSP and CBD who were admitted to our palliative care unit from Mai 2006 until April 2008.
Results: Within these two years there were 13 patients admitted, 9 diagnosed clinically with PSP and 3 with CBD. The mean age was 72 ± 6 years (57-81 years). The duration of treatment varied between 1 and 21 days (10 ± 6 days). The most common reasons for admission were pain (n = 7), diarrhoea/ obstipation (n = 6), swallowing difficulties (n = 5), sialorrhoea (n = 4), dyspnoea (n = 4), depression (n = 4), sweating (n = 3), myoclonic jerks (n = 2). Treatment options of these symptoms are comparable to the established methods and drugs used for patients with malignant diseases. Two of the patients died during the time at the palliative care unit.
Conclusion:
1. The reasons for admission and the time at the palliative care unit are not different between patients with PSP and CBD and patients with malignant diseases.
2. Symptom control has been very effective in these patients with the knowledge of the underlying disease.
3. We emphasize that more patients with these diseases find their way to palliative care units.

PE 2.S242

Palliative care for the patient with severe neurological damage - Practice in occupational therapy

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Palliative care is an important reference for the assistance to the patient of severe neurological damage: quality of life, comfort and impeccable assessment and treatment of pain end other symptoms are the main goals of the assistance. The occupational therapist can contribute to this assistance by offering sensorial stimulus and introducing meaningful activities in the daily life of the patient.
Aims: Identify the procedures, and their results, done by the department of Occupational Therapy in the assistance for the patient with severe neurological damage in a Palliative Care service.
Methodology: Retrospective study, qualitative methodology, through the analysis of register in medical records. Twenty four medical records of patients were analyzed (delimited number by the saturation criteria) between the period of May 2006 and September 2008. A guideline was done for the collecting data and the analysis was done based on the identification of the main thematic groups.
Results: The main procedures taken by the occupational therapist were: sensorial stimulus, inclusion of the patient in group work, splint manufacture and adaptation for the bed positioning and adaptation to wheelchair, guidance and support to the caregivers and specified orientations to the nursing team. The main therapeutical resources were: subtle touch, music, massage, expressive activities. The results were: increase of quality, duration and consistence of the responses to the stimuli; creation of new possible

ways of communication, such as blinking and gestures, and expressing feelings; tranquility in the moments of anguish and anger; and also emotional support to the caregiver.
Conclusion: Although the patient may have strict disabilities, there should be room for testing and welfare; the above study showed how Occupational Therapy in Palliative Care Services can offer new possibilities of attendance and care, contributing to the improvement of the quality of life.

PE 2.S243

Palliative care and COPD-related fatigue - Exploring the knowledge

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Introduction: Traditionally in Poland, hospice care is focused on patients with malignant diseases However, palliative medicine services have recently attempt to involve patients with other chronic, life - threatening diseases, eg. chronic obstructive pulmonary disease /COPD/. In this group of patients both quality of life and life expectancy is poor. The Best Supportive Care of these patients means not only the clinical symptoms control, but also the holistic, multiprofessional approach.
Aim: To investigate how the patients experience common symptoms of end-stage COPD. Our study focused on the relationship between COPD - related symptoms, especially fatigue, and positive and negative emotions /e.g. anxiety, depression/. Can COPD symptoms be responsible for the level of COPD-related fatigue?
Methods: 30 patients suffering from COPD were involved into study. The patients were examined with Charlson Comorbidity Index, VAS-pain, VAS- fatigue, HADS and Multidimensional Fatigue Inventory /MFI/. The information on the pharmacological treatment was collected. The association between the level of patient's fatigue and COPD-related symptoms was evaluated using the multifactorial ANOVA analysis.
Results: COPD- related fatigue is very common and a multifactorial problems. The influence of COPD-related symptoms on the level of fatigue has been confirmed. The major symptoms were dyspnoe, fatigue, depression, emotional and psychosocial problems.
Conclusion: The suffering of patients dying from COPD is not mild than cancer patients. The patients express the need for palliation of symptoms and end-of-life support. This study showed the role of additional factors and co-morbidities in the course of end-stage COPD. That palliative care is very important for patients with fatigue and chronic uncontrolled symptoms so further follow-up and development should be done.

PE 2.S244

Obduction of patients with neurodegenerative diseases dying at a palliative care unit

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Aim: Only recently admission of patients with neurodegenerative diseases are more common at palliative care units. The definitive clinical diagnosis of neurodegenerative diseases (e.g. dementias, atypical Parkinsonian disorders) is often difficult and only neuropathological examination of central nervous system tissue might confirm the diagnosis. Therefore, obduction of patients with neurodegenerative diseases is strongly recommended.
Materials and methods: We report on the possibility of obduction of patients with neurodegenerative diseases who died on our palliative care unit between 1.1.2007 and 31.09.2008.
Results: Within this time 52 patients with neurodegenerative diseases were admitted to our palliative care unit. The most common neurodegenerative diseases at our palliative care unit are amyotrophic lateral sclerosis (ALS), atypical Parkinson's diseases like progressive supranuclear palsy (PSP), multiple system atrophy (MSA), cortico-basal degeneration, dementias, and rarely Creutzfeld Jacob's disease, Chorea Huntington or M. Fahr. In 2007 5 patients with neurodegenerative diseases died and on 1 of them with PSP an obduction has been performed which has confirmed the clinical diagnosis. In 2008 8 patients with neurodegenerative diseases have died so far and on 5 of them (ALS, MSA, PSP, 2 cases of dementia) an obduction has been performed. The increasing number of obduction might be associated with a more concise management of communication with the patient and / or the relatives.
Conclusion:
1. Obduction of patients with neurodegenerative diseases provides the family and the clinicians with a final diagnosis of the disease.
2. Valuable tissue for research purposes can be obtained from cases with neurodegenerative diseases and might enhance research and treatment of these diseases in the future.
3. We emphasize a management plan to increase the number of obductions of patients with neurodegenerative diseases dying on palliative care units.

PE 2.S245

Modelling specialist input in hospital inpatients with non-malignant palliative care needs: A pilot

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Aims: The project had the following principal aims:
- To provide more systematic palliative care to patients with non-malignant conditions
- To identify whether this model of care enhances patient care/experience in this population.
Methods: The project was a mixed qualitative and quantitative study, using semi-structured inpatient consultations. Symptoms were assessed using self-reported 10 point scales (Brief Fatigue Inventory, Modified Borg Scale, local protocol) wherever possible. Interventions included:
- Pharmacological manipulation
- Psychological input
- Multi-professional assessment/referral
- Hospice involvement
- Family communication
- Professional communication.

Results: 21 patients were assessed. Following exclusions (2 patients with concurrent malignancy, 1 with acute pain secondary to burns) 18 patients' records were analysed.
The majority of referrals were received from Respiratory and Cardiology wards (39% and 22% of patients, respectively) and in all cases, a high incidence of multiple comorbidities was noted (50% of patients having 3 or more concurrent illnesses). Symptom burden was also significant, with most patients experiencing 3 or more. Median symptom scores were 7/10 for dyspnoea and fatique and 4/10 for pain - the three commonest symptoms.
Pharmacological intervention was extremely common (94%), as was referral to other professionals, and for ongoing specialist palliative care.
Qualitative data showed that the team assisted other teams in recognising & managing the end of life.
Conclusions: This study's results show much of the input provided was concerned with assisting in recognition of the dying phase, management of symptoms and support for relatives (and staff) at end of life. The implication for palliative care services is that the demands of extending service provision to patients with non-malignant disease represent a major challenge which requires either a change in the service offered or new resources.

PE 2.S246

The Royal Marsden Hospital2Home pilot project: Developing a new model of co-ordinated complex care for terminally ill patients using case conferences and information technologies

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Around 500,000 people die in the UK each year 1, the majority would prefer to die at home but nationwide 58% die in acute hospitals,18% at home, 17% in care homes, only 4% in hospices and 3% elsewhere.
Aim: The Hospital2Home (H2H) pilot program, based on the Australian model is a case conference (CC) organised for patients nearing the end of life. The aim is to increase the number of patients dying in their preferred place.
Method: Patients are referred to the H2H when no further active treatment is appropriate, with the patients consent, a CC is organised in their homes. The patient, carer, H2H CNS, GP, district nurse, and palliative care nurse are invited. A care plan is agreed with a responsibilities for care identified.
Results: The H2H Pilot Program started in Oct 2007, 95 patients have entered the program, 28 are still alive, and 67 patients have died.
The CCs were attended by GPs 78(82%), district nurses 89 ((94%), social workers 23 (24%), Spiritual 2 (2%), carers 95 (100%). The preferred place of care (PPC) was home for 95(100%) patients. The preferred place of death was not discussed with nine patients(PPD) as it was not appropriate. Of the remaining 86 patients the PPD was home for 52 and hospice for 34.
Actual deaths of H2H vs National data in %: home (32 vs 18%), hospice (52 vs 4%) and hospital 10 vs 58%). When H2H patients were compared to the National cancer deaths home deaths were increased ($p=0.04$,Chi2 4.4), hospice deaths were increased ($p<0.0001$, Chi2 63) and hospital deaths were decreased ($p<0.0001$, Chi2 60).
The total number of days spent at home or a hospice was 5,889, 147 days (2.5%) were spent in hospital.
Conclusion: CC results in increased death at home and hospices and decreased deaths in hospitals. Further work to assess quality of life, and health economics is needed. An electronic summary care record is being developed that can be accessed by all professionals.

PE 2.S247

Development, structure and function of a community based urban palliative care consultation team (PCCT)

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Virtually all Palliative Care services in the USA are hospital based. The Metropolitan Jewish Health System (MJHS) Urban Palliative Care Consultation Team (PCCT) is community based. The PCCT provides Specialist Palliative Care assessments using a consultative model in New York City, Brooklyn, Queens, the Bronx and Nassau County Long Island. The PCCT is composed of Hospice and Palliative Care certified professionals including a Physician, three Nurse Practitioners, two Social Workers, a Chaplain and Volunteer coordinator. The PCCT uses an Interdisciplinary Team (IDT) model and acts as the "eyes and ears" of hospital based PCCTs, Certified Home Health Agencies, Comprehensive Cancer Centers and community based medical services. The average daily census (ADC) has grown to ~150 since January 2007. Most patients are in their sixth decade with neoplastic diseases comprising 30% of the ADC. Fifty per cent growth is projected for the upcoming fiscal year. The PCCT participates in postgraduate medical education and will engage in healthcare system research. The PCCT budget is funded by philanthropic organizations, the MJHS and billing of healthcare insurance entities. The MJHS Urban PCCT provides continuity of care for patients and their famiiles seen by hospital based PCCTs.

PE 2.S248

District nurses, palliative care and relationships with patients: A realist review

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Background: District nurses in the UK frequently provide much home based professional care to palliative patients and families. Their role is pivotal to the delivery of current end of life policies. Understanding their role and how they enact this role is critical to the provision of a coherent, comprehensive palliative care service.
Aims of study: This study aimed to review current research to understand how, why and when district nurses provide palliative care.
Study design and methods. Realist reviews facilitate understanding of complex roles. They are theory driven, using empirical evidence to support or refute underpinning theories of roles or programmes. First, district nursing theories were identified. Second, 6 electronic databases (1990-2008) were searched, combining terms for district nursing and palliative care. 63 studies were selected to review from over 3000 'hits' and associated citation tracking. Third, studies were appraised, evidence extracted, and identified theories interrogated.

Results: Many theoretical aspects of the district nurse role were supported by evidence including their valuing of and commitment to palliative care and home as a care context. The most strongly supported theoretical element concerned their relationship with patients. District nurses felt that forming relationships with patients was the foundation of palliative care, and the medium through which other care is given. Patients and carers valued a caring friendship. Nurses and patients may have different perspectives about their relationships. Little research incorporated the views of both nurses and patients on the district nurse role, or observed how roles and relationships were enacted in practice.
Conclusions: The district nurse role is important, but patient and nurse interpretations of this role may differ. Further research is required which incorporates nurse and patient views, and which observes the district nurse role in practice.
Funding: Research Council UK

PE 2.S249

Recognising the hidden volunteers in palliative care: A survey of hospice trustees in the United Kingdom

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Background: Independent, charitable hospices in the United Kingdom (UK) rely heavily on volunteers to perform diverse and important roles in supporting the provision of palliative care. Trustees are a group of volunteers who are responsible for the governance and strategic direction of hospices. Very little previous research has focused on hospice trustees; therefore a national survey was undertaken to explore their profile, roles and views.
Methods: A 27-item questionnaire was developed, with questions focused on motivation, recruitment and selection procedures, length of time in post, specific roles and responsibilities, training, appraisal, future plans, and the extent to which trustees felt valued, fulfilled, supported, and part of their hospice. Demographic data were also collected. The questionnaire was sent to 2015 hospice trustees in the UK; 610 were completed and returned (a response rate of 30.3%). Numerical data were analysed for frequencies and cross-tabulations using SPSS 14.0 for Windows, and open-ended comments were subjected to qualitative thematic analysis.
Results: Two thirds of respondents (66.4%) were male and over 95% were white British. Over 62% of respondents were aged 60 or over and only 2% were under the age of 40. Almost half (47%) were retired, and over 92% were from professional or senior management occupations. Nearly two thirds (62.3%) were personally invited to join the Board, and only 5.7% answered an advertisement. The majority of respondents felt highly valued, supported and fulfilled in their roles, and felt part of their hospice. However, only 19% had ever had a performance appraisal, whilst over 60% said they would like one.
Conclusion: Current trustees are typically older, retired, professional men, and UK hospices may benefit from greater diversity amongst trustees. There is also scope for the provision of more formal support for trustees, as the high demand for regular performance appraisals is not currently being met.

PE 2.S250

Palliative care for cancer patients in Albania

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Aim: The purpose of this material is the presentation of the development of palliative care for cancer patients in Albania, focusing on Korca region. (South East part of Albania).
Methods: The material used for this abstract is received from the data of work with cancer patients in several institutions in Albania, such as: Onclogy Hospital Tirana, Ryder care Albania, in Tirana and Durres branches and Korca Palliative care for the data of South East region. The patients that have received care in Korca Palliative care centre have been studied from January 2004 till September 2008.
Results: The number of palliative care teams working in Albania has increased over the years. There has been an increase also in the number of team members in Korca Palliative Care Centre from 8 team members in January 2004 in 10 in September 2008. Staff capacities have improved through continuous professional training and work experience. The number of patietns receiving care in Korca Palliative care centre has increased from 119 patients for 2004 in 155 patients in 2007 and 149 patients from January - September 2008. The activities offered have extended from home visits only, to respite care, day care, chemotherapy administration and education.
Conclusion: Palliative care in Albania is offered mainly to cancer patients, as it has developed recently as a new specialty. This results from the increasing number of palliative care teams in Albania, extension of existing teams and multidisciplinary teams, continued raise of capacities within teams and increasing number of patients that seek care.

PE 2.S251

Analysis of 24 hour specialist palliative care telephone advice

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Telephone advice is an important aspect of palliative care for health professionals and patients/carers. At our 24 bedded independent hospice 24 hour specialist palliative care telephone advice is available, but prior to this study it was unclear how well this resource was utilised. Monitoring the nature and uptake of this service has highlighted the needs and access of public/professionals to specialist palliative care telephone advice.
Aim: To audit and analyse the nature of telephone advice.
Methods: A nine-month prospective analysis of telephone advice given by the hospice was undertaken. Information gathered included: telephone caller/receiver details, diagnosis, advice sought, outcome and timing of call.
Results: 168 calls were documented. Among the callers, 46% were carers, 8% patients and 42% health professionals (52% primary care, 35% secondary care). Medical and ward nursing staff dealt with the majority of calls (43% and 51% respectively). Advice regarding symptom control accounted for most calls (63%), followed by pharmacology or syringe driver advice (24%). Other issues including admission requests, social and equipment needs and bereavement made up the remainder. 55% of calls required palliative care follow-up action (usually community follow-up review). Just 10% of calls referred to patients with a non-cancer diagnosis. 54% of calls occurred out of hours (43% weekend calls), and 74% were about patients known to the hospice.
Conclusion: Analysis of the advice provided important information on the present need and uptake of specialist palliative care telephone advice. Overall the uptake of advice was lower than expected and in particular patients not known to the hospice and those with a non-cancer diagnosis poorly utilized the service. In response to these issues a questionnaire is being conducted to primary and secondary health professionals to highlight the provision of specialist palliative care telephone advice to these groups of patients.

PE 2.S252

Enhancing palliative care services in the emergency department of an acute tertiary care hospital

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Aim: This study aims first, to identify trends in palliative care consults and Acute Palliative Care Unit (APCU) admissions originating from the Emergency Department (ED); second, to assess ED staff's perceptions and needs regarding palliative care services; and third, to explore some of the financial implications of these referral patterns.
Methods: This study includes a retrospective analysis of Palliative Care Consult Service (PCCS) and hospital administrative databases, measuring trends over 5 years and a survey of ED staff (physicians, nurses, and social workers).
Results: ED requests for Palliative Care Consults increased following the opening of the APCU. In the 3 years prior to its opening, the ED requested 13 consults. This increased to 23 in 2006, 101 in 2007, and 51 through mid-July, 2008. Major reasons for consults were end of life issues in 127 (66%, 95% CI 59-73%), and symptom management in 33 (17%, 95% CI 12-23%). Sixty one percent of patients in the database died during the hospitalization (115/190, 95% CI 53-68%). Diagnoses included: cancer (70), chronic disease (46), infectious disease (13), intracerebral hemorrhage (12), respiratory failure (12), cva (10). A survey of ED staff will identify ways the PCCS can assist in meeting patients' palliative care needs earlier in their hospitalization. Patients admitted directly to the APCU from the ED resulted in greater cost avoidance.
Conclusion: In August, 2006 Summa Health System opened an APCU to expand services already provided by an established PCCS. This brought a significant increase in PCCS requests from the ED. The availability of a PCCS and APCU support ED physicians' ability to efficiently meet patients' palliative care needs. Strengthening collaboration between the ED and the PCCS will result in more efficient protocols for meeting both patient and health care provider needs in the ED.
This study was funded by the Summa Foundation.

PE 2.S253

Patient and family preferences regarding accommodations within palliative care units

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Aims: The interdisciplinary hospital palliative care support team at the Wilhelminenspital, the second largest hospital in Vienna, supports patients with incurable diseases within all departments. More than 50% of those palliative patients who are attended by this team are able to stay at home after discharge, but a few of the patients need special treatment in a palliative care unit. In this study we wished to discover what individual preferences palliative care patients and family members have concerning the accommodation in a palliative care unit.
Methods: Between 1st April and 30th September 2008 we asked 93 patients and 47 family members for their preferences. 47 female and 46 male patients and 47 family members (35 female, 12 male) were interviewed in a standardized questionnaire with the following options: single room, double room or more than 2 beds in the patient's room. The median age of the patients was 69 (29 - 92), the median age of the family members was 60 (28 - 88).
Results: 44% of patients who were to be transferred to a palliative care unit preferred a single room, 43% a double room, 5% a room with more than 2 beds and 8% had no preference. There were differences between male and female patients: most male patients wished to stay in a double room (50%), female patients preferred a single room (53%). 43% of the family members wanted a single room for the patient, but 53% desired a double room for the patient and only 4% wished a multi-bed room for the patient.
Conclusion: This investigation shows that half of palliative care patients preferred a single room in a palliative care unit and most of the family members wished a double room for the patients. The evaluation may be helpful for those who plan to establish a palliative care unit, especially in the German speaking countries (Germany, Switzerland and Austria) where there is a growing trend to plan and construct palliative care units with only single bed rooms for the patients.

PE 2.S254

Who you gonna call (in an emergency at home)? Do community palliative care patients and their relatives know who to call in an emergency?

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Background: There is increasing emphasis on moving palliative care into the community and providing support to patients wanting to be at home. Our community palliative care team wanted to evaluate whether patients and relatives know who to call in an emergency situation, when at home. This patient group is very prone to emergencies.
Methods: We conducted a standards-based prospective audit on 30 palliative care patients in the community. The aim was to establish whether patients and relatives knew who to call in an emergency at home. A standard was agreed at our local audit meeting and audit committee approval was sought. Data was collected by community nurse specialists and doctors in palliative

care using an audit form (proforma) whilst visiting patients at home. Patients and carers were asked whether
a) they knew who to call in an emergency and
b) to explain who they would call in such an event.
Results: Of 30 patients questioned, 10 (33.3%) did not know who to call in an emergency and did not have a list of numbers. 20 answered that they knew who to call and answers included district nursing service, family doctor and emergency number (999).
Conclusions: It was decided that an intervention was necessary, in the form of a list of phone-numbers in the patient-held district nursing notes and that patients/carers should be alerted to this list during all future visits and phone-calls. There is a lot of available data that community palliative care is inadequate across many industrialised countries. A simple intervention in the form of explanation and an emergency phone-list can make all the difference to this vulnerable group of patients, when unexpected events happen out-of-hours. We will also present the second stage of the audit collected 6 months later (thus completing the audit-cycle) to show whether this community phonelist intervention has been successful and these results will form part of the poster presenation proposed for the EAPC conference in Vienna.

PE 2.S256

Answering to the need to manage, collect and process clinical data in a home palliative care unit: A web-based case sheet

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Aim: The management of clinical data of a home care unit has to be considered one of hardest question to solve; manage, collect and process clinical data is a prioritarian question that has to be solved simplest as possible, to allow the operators to be through keeping less time as possible.
Methods: We projected and built a web-based cese sheet, using the internet to connect real time operators between they all and with the head office, to simplify news exchange, management of daily plan, drug and tools distribution and processing data. Every operator works with a notebook connected to the website that support the case sheet.
Results: The project, now in start-up phase, will allow the home care unit's oparators to keep communication between they all, trough real time data exchange; an automatic email delivery system will ensure connection with people (other than the palliative team) involved in patient's care; moreover, the system allows to process automatically clinical data, to simplify assessment procedures and research activities.
Conclusions: In our opinion the web-based case sheet could be an important instrument to emprove assistance's quality, allowing to reduce spending time for data management and to encrease clinical activity; moreover, an automatic system to manage and process clinical data could be very useful to make research activity faster and easier, minimizing too the risk of missing data. We think that this operative system could be purposed for extended use in palliative home care units.

PE 2.S257

Geriatric palliative care interest group of the European Union Geriatric Medicine Society (EUGMS)

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Research aims: Populations are ageing at increasing rates. As more people live longer, new challenges are emerging. The dying trajectory of frail, older patients is quite different from this of younger patient often dying from cancer. The older patients often accumulate multiple chronic medical conditions and geriatric syndromes and present multiple, frequently unpredictable, exacerbations of their disease. To provide adequate palliative care to this population some specific skills are necessary.
Methods: In March 2007 a group of European geriatricians involved in geriatric palliative care (GPC) met the first time to discuss the current situation of GPC in Europe. This group became an official recognized group of the EUGMS and met for the fourth time in September 2008.
Results: The group decided some rules for the participants (maximum 2 or 3 per country): to be European geriatricians involved in GPC, to be recommended by Geriatric Society of their country, to participate actively and to attend regularly to the meetings. Main goal of the group is to establish a European network of physicians to improve GPC. Secondary goals are to establish a link between palliative care and geriatric societies on national and European level, to offer advice concerning GPC to EUGMS and national geriatric societies and through EUGMS to European policy makers, governments and health care planers. Further goals are to communicate a definition and specificities of GPC, to make a survey about existing structures in GPC, to establish a research network for GPC, to collect and disseminate evidence and guidelines, to promote teaching and training in GPC and to find financial support. A project of definition will be presented and the survey will be send soon to participants of main European countries.
Conclusion: To achieve all the different goals during the next years, European geriatricians are going to need a lot of energy and support from the different European societies and networks.

PE 2.S258

Model of communication between palliative care services and primary care emergency and continued services

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Objective: To describe the model of communication between the In-Home Supportive Care Service and the Emergency Primary Care Services in the Spanish Health Area of Gijón.The In-Home Supportive Care is delivered by primary care professionals specialized in providing medical care to patients with terminal or complex chronic diseases. The supportive care is undertaken from 8:00 to 15:00 from Monday to Friday, whereas physicians of the Primary Care Emergency Services cover the service during the rest of the time. A palliative care integral program allowing an agile and efficient communication between both health care teams was developed, to provide flexible care and integration of services between acute care centers and home support teams. It's specially directed to patients who are either dying or under unstable situations in whom pain, dyspnea, vomiting, agitation or other critical symptoms are expected to emerge.The integral program is aim to deliver by fax a standardized medical report from the In-Home Supportive Care team to the emergency primary services. This report contains a first section with patient personal details. The second includes clinical information with special emphasis in the oncologic history. The current medical treatments are described in the third section. The last and largest section is used to describe the expected patient incidents such as pain crisis, dyspnea, agitation or death. The specific treatments recommended by the experts in palliative care, who have a complete knowledge of the evolution of the patient, are also described in this section.
Conclusions: In 2007 we treated 150 patients that died at home. Standardized reports concerning 90 of the 150 patients were sent to the emergency primary services. Preliminary data suggest that most emergency physicians have a very positive opinion on this program, and consider it very valuable for the proper in-home management and treatment of terminally ill patients in emergency situations.

PE 2.S259

Reaching out with palliative care: An evaluation of a community volunteer programme in Uganda

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Background: In Uganda in each year approximately 27,000 new cases of cancer are reported affecting 1.5% of the population.1 However a shortage of Doctors, wide geographical distribution, and poor transport systems leads to many patients especially in rural areas experiencing severe uncontrolled symptoms.
Hospice Africa Uganda developed a community volunteer worker programme where local villagers are trained to identify patients with palliative care needs. The volunteers refer patients to the hospice and provide basic care and support for patients and families. A training course with ongoing support has resulted in 45 volunteers currently practicing. The volunteers receive no payment, except for a bicycle enabling them to reach remote rural areas. The aim of this study was to evaluate the impact of the volunteer programme on patients, hospice staff and volunteers.
Methodology: A qualitative methodology using semi structured individual and group tape recorded interviews was adopted for the study. A purposive sample of a volunteers (22), patients (11) and hospice staff involved with the programme (2) were invited to participate in the study. Data was analysed for emerging themes using thematic analysis.
Results and discussion: The volunteers were seen to be providing a positive impact to patients in helping them to receive appropriate care and intervention from the hospice team; additionally they were providing basic nursing care, support and advice to patients and their families. For volunteers, the role increased their confidence by providing care for their community. Additionally for the hospice team it enables patients in rural areas with palliative care needs to be identified and provided with appropriate care. This paper will discuss the findings from the study and provide an overview of the structure of the programme.
1 Makokha T Africa no longer willing to suffer in silence. Cancer World 2006 Dec- Jan Special Issue 42-45

PE 2.S260

Global need for palliative care and palliative radiotherapy

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The global burden of cancer will increase from 10 million to 24 million in the next 50 years; more than half of cancer cases will be diagnosed in low income nations, and a large proportion of these patients will have incurable disease at the time of diagnosis. Based on these statistics, palliative care will remain the most important intervention in oncology worldwide. Because palliative care specialists can reach only a small proportion of these patients, feasible solution is to incorporate palliative care principles as a standard of medical care for all health care providers. This is needed to raise awareness of the need to minimize suffering, of the current recommendations and trends in palliative care and of the role of radiotherapy in palliative cancer treatment. Great variability exists in the integration of palliative care within the wide range of health care systems worldwide. In minority of countries some integration within existing health care systems is in place, and have been achieved recognition within health care policy. This does not come close to meeting the global need for palliative care. Access to palliative care is closely related to quality of the health care system. Barriers may be found in low prioritization of palliative care in health care policy and in healthcare education.
To provide comprehensive care, multidisciplinary approach is needed to utilize the available targeted treatments and to ensure cost effective ethically sound approach for cancer patients during each stage of the disease. Quality management and quality systems need to be incorporated to all levels of care.
IAEA has produced a document based on consultant meeting to review the global efforts in providing palliative care along cancer treatment focusing on palliative radiotherapy services and practice.

PE 2.S261

A specialised palliative care unit in a nursing home - Organization and patient characteristics

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Aims: To describe the organization and patient characteristics of the specialized Palliative Care unit at Bergen Red Cross nursing home.
Background: This unit has been established in the year 2000 and its aim is to serve especially elderly

people in need for Palliative Care. It has 8 short-term places for palliative patients and 6 long-term places for nursing home patients, where most also need skilled Palliative Care and medical supervision. The patients both come from their home or the hospital and are admitted by recommendation of a physician.
Methods: All patients admitted in 2007 were registered including number of patients who were admitted, age, gender, diagnoses, length of stay etc.
Results: 84 patients were admitted to the Palliative Care unit in 2007. 51 were female and 33 male, average age was 74.5 years. 75 patients died during their stay, 9 were discharged to their own home, and 8 were transferred to a long-term place in a nursing home. Some patients had more than one stay and were re-admitted after a period in their own home. Most patients had a cancer diagnosis and many suffered from pain and other troublesome symptoms.
Conclusion: Although many elderly people do need Palliative Care, the majority of the patients admitted to our specialised Palliative Care unit were cancer patients. Possible causes for this observation are that the Palliative Care needs of elderly non-cancer patients are often overlooked and that elderly cancer patients have more often complex problems, which may lead to a higher frequency of admissions to a specialised Palliative Care unit.

PE 2.S262

Dying at home - What can Primary Home Care (PHC) teams in Austria contribute?

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Aim: Whereas the support for the wish to die at home is usually considered to be the task of specialized palliative care teams, this study directs attention to PHC, which is provided by certified nurses and health care assistants. The qualitative study, commissioned by the Austrian Red Cross, is devoted to the following research questions: What resources and barriers for palliative care are there in PHC? What changes are necessary in organizational structures and framework conditions within and for PHC?
Methods: 3 PHC teams in different Austrian regions were included in the qualit. research. Sample: 9 qualit. interviews with home care professionals. 10 qualit. interviews with different cooperation partners. 3 interprof. group discussions with 44 caregivers. 14 after death interviews with family carers. Data analysis: qualit. content-analysis and grounded theory.
Results: PHC increasingly called upon to provide care for palliative patients. Barriers for palliative care at home are seen in: the absence of framework conditions and resources in the health care system; too rigid organizational structures that allow too little flexibility in care; the self-image and care practices of PHC that are rooted in old paradigms; lack of established routines of cooperation with palliative care teams and family doctors; no established routines in ethical decision-making processes; lack of palliative care know-how. Resources: the individual commitment of home care nurses for their patients.
Conclusion: PHC must move beyond tradition patterns of care with respect to both health care policies and the self-image of PHC. This means making a transition from care concerned solely with the bodily requirements of the person requiring care to a systemic understanding of care that is, on the one hand, focused on the recipients of the care (oriented to the needs of the family system) and, on the other, takes into full account the organizational cooperation that is necessary.

PE 2.S263

Case management for transitions in lung cancer care

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Aim: Utilizing the Pan-Canadian Gold Standards for Case Management for Hospice Palliative and End-of-Life Care at Home, an outpatient cancer care program, a teaching hospital and a community-based palliative consultation service worked in partnership to develop an intervention to improve referral services for lung cancer patients. The purpose of this study was to develop, implement and evaluate a case management tool to support collaborative practice and effective transitions in palliative care services for Stage 3 & 4 lung cancer patients. The objectives were:
1)To assist the cancer centre health care team in decision making regarding the most appropriate palliative care service provider;
2) To support a primary health care model for community palliative care service delivery; and
3) To improve continuity and communication among health care providers, patients, families and services across sectors and settings of care.
Methods: This intervention study consisted of the development and implementation of a clinical decision making algorithm and utilized mixed methods for evaluation including focus groups, surveys, and interviews with interprofessional team members. Pre-intervention and post-intervention chart audits were conducted to track referral patterns and utilization of the tool.
Results: Study findings will be presented demonstrating the benefits of and barriers to a partnership approach to improve case management for transitions in lung cancer care. Health care system issues will be addressed. The study is in progress and analysis will be completed by April 2009.
Conclusion: It is expected that an interprofessional primary health care model will address gaps in health services for advanced lung cancer patients by improving clinical decision making regarding the appropriate provider and setting of care and improving continuity of care. Recommendations for policy and practice will be discussed.
(Funded by CIHR End-of-Life-Care for Seniors Team)

PE 2.S264

Charting the historical development of pioneer palliative care services across Europe: A review of the literature

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Background: Since St. Christopher's Hospice in London was established as the first 'modern hospice' in 1967, hospice and palliative care have spread throughout the countries of Europe.
Aim: This paper charts and summarises the historical development of pioneer palliative care services across the continent by identifying the date and the name of the first service to be established in each European country.
Methods: Data on the historical development of pioneer palliative care services across Europe were gathered from a number of sources: published works, a systematic review of hospice and palliative care publications, and individual country reports compiled by the EAPC Task Force on the Development of Palliative Care in Europe.
Results: Data relating to the historical development of pioneer palliative care services across Europe was identified in 44/52 (85%) European countries surveyed. With the exception of the United Kingdom, pioneer palliative care services began to develop across Western Europe in the mid 1970s. In the countries of Central and Eastern Europe and Commonwealth of Independent States, there has been a steady development of pioneer palliative care services since the political upheaval of the 1990s. There are a number of European countries in which more than one 'pioneer service' emerged at approximately the same time, resulting in much debate about the legitimacy of the 'original' pioneer service. The range of pioneer palliative care services across Europe, and the order in which each has been established is highly diverse.
Conclusions: Charting the historical development of pioneer palliative care services across Europe provides a broad summary of variations over both time and location and poses a number of salient questions concerning the future development of palliative care services across the continent.

PE 2.S265

Barriers to the development of palliative care in Western Europe

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Background: The 'Eurobarometer Survey' produced by the EAPC Task Force on the Development of Palliative Care in Europe compiled comprehensive information on the provision of palliative care across the European region. This paper focuses on one part of the survey relating specifically to 22 countries in Western Europe.
Aim: To identify barriers to the development of palliative care in Western Europe.
Method: A qualitative survey was undertaken amongst boards of national associations, eliciting opinions on opportunities for, and barriers to, palliative care development. By July 2006, 44/52 (85%) European countries had responded to the survey. We report here on the results from 22/25 (88%) countries in Western Europe.
Analysis: Data from the Eurobarometer survey were analysed thematically by geographical region and by the degree of palliative care development.
Results: From the varied data contained within the Eurobarometer, we identified six significant barriers to the development of palliative care in Western Europe:
(i) lack of palliative care education and training programmes
(ii) lack of funding
(iii) lack of coordination amongst services
(iv) prejudice relating to the use of opioids
(v) lack of public awareness and government recognition of palliative care as a field of specialisation
(vi) uneven palliative care coverage.
Conclusion: Despite huge variations in the levels of provision across many countries, data collected in the Eurobarometer survey reveal many common barriers to development of palliative care in Western Europe.

PE 2.S266

Paediatric palliative home care by paediatricians in their own practice: An example of general palliative care delivery

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Aims: Non-specialist palliative care, as it is delivered by general practitioners, is a basic component of a comprehensive palliative care infrastructure. Currently palliative care networks for children and adolescents are recognized as a distinct entity of care. The aim of this study is therefore to examine potential barriers, facilitations, and the professional self-image of paediatricians in their own practice with regard to paediatric palliative care.
Methods: Based on qualitative expert interviews, a standardised questionnaire was developed and pilot-tested for content validity and comprehensibility. The survey has been developed and performed in close cooperation with the regional professional association of paediatricians. The questionnaires were completed at the regional quality circles.
Results: The results show a high disposition on part of the paediatricians to commit themselves to palliative care, and the majority of respondents regard palliative care as part of their profile. Main barriers for the implementation are time restrictions and financial burden, sole responsibility without team support, as well as formal requirements such as forms and prescriptions. Major incentives and facilitations are support by local specialist services (e.g., home care nursing service), access to a specialist consultation team, as well as the possibility of exchange with colleagues.
Conclusions: A local network of specialist support by phone and on site is necessary in order to facilitate the implementation of basic palliative care by paediatricians in their own practice. Further research is needed in order to examine whether the results can be extrapolated to general practitioners and adult palliative care.
The survey is part of the accompanying research of a pilot project funded by the Department of Health of North-Rhine Westphalia, Germany.

PE 2.S267

Speciality of doctors working in palliative home care in Estonia

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Aims: The aims of this study were:
(1) to find out what is the speciality of the doctors working in palliative care;
(2) how many years have they worked in palliative care; and
(3) how many years have they worked as a doctor on the whole.
Methods: Telephone interviews were made to the doctors working in the palliative home care system in June 2008. This system was launched 11 years ago and is specialized for advanced cancer patients. We inquired about the age of the doctors, their speciality, number of years worked in palliative care and as a doctor on the whole. The SPSS Base System for Windows 10.0 was used for data analysis.
Results: The study group was 17 doctors, 11 (65%) of them were women and 6 (35%) were men. The mean age ± standard deviation (SD) of the doctors was 58 ± 11 years.
The most prevalent speciality of these doctors was surgery, followed by internal and general medicine.
The number of years worked as a doctor on the whole varied from 11 to 58 and the mean number ± SD was 32.65 ± 13.03.
The number of years worked in palliative care varied from 1 to 11 and the mean number ± SD was 6.71 ± 0.57.
Conclusions: There are different specialists working in palliative care thus they differ from their background, knowledge and skills. Continuous training-courses can harmonize knowledge and give basic information. However, there is an increasing need for specialization for palliative care. The doctors working in this system have been worked quite a many years already. So they should be quite experienced in medicine, and motivated, as they have been working in the same system for many years.

PE 2.S268

Role of palliative care heart failure nurse specialist

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Background: Heart failure is a non-curative, highly prevalent and often symptomatic and debilitating condition. It is recognised the importance of the availability of specialist palliative care services to patients with non-malignant disease, including heart failure. The was established in March 2008 in Whiston and St Helens Hospitals and St Helens Primary Care Trust.
Aims: The aim is to promote palliative care to patients with heart failure, and so reduce hospital admissions, increase home deaths, ensure patients have a management plan, and so improve patient care and quality of life.
The role
One day a week is spent working with the Hospital Specialist Palliative Care Team on in-patient wards, and 2 days a week with St Helens Community Heart Failure Nurse Specialists. Cross boundary working provides continuity for patient care, and support and advice to health care professionals. The role involves varying amounts of involvement depending on the situation and close links with the local hospice.
Implementing the role
Following assessment necessary patients are placed on the palliative care register and patients wishes documented. Symptoms such as breathlessness have been improved through advising GPs, reducing anxieties and attending day therapy at the local hospice. This has contributed to reducing hospital admissions and 4 patients have died at home and 2 in hospice.
Conclusion: The role is challenging, rewarding and varied, with a positive effect on patients' quality of life. Cross boundary working gives continuity and palliative care peer support. Working 2 days in the community can be limiting. Further discussion is required to audit the role in the future.

PE 2.S269

"Convenience Store!" - Improving access to palliative care medicines

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Background: Many people prefer to die at home but are unable to do so. Approximately 26% of patients die at home, yet many more would choose this as their intended place of care. The difficulty obtaining medicines required to control dying patients' symptoms in the community setting may be a contributing factor.
Method: Through collaboration between specialist palliative care services and local NHS Primary Care Trusts a scheme was introduced to overcome the difficulties in obtaining palliative care medicines.
Conclusion: This presentation will outline the successful implementation of a scheme in which community pharmacies were contracted to stock an agreed list of palliative care medicines. It will focus on the process and how to overcome the barriers of implementation and the informal evaluation of community health professionals utilising the scheme.

PE 2.S270

Reviewing hospice services - An inclusive approach

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Organizational review is necessary to provide evidence of excellence in care provision and to determine future development.
The same method has been used successfully for 3 major reviews of specific hospice services:
• Terms of Reference agreed at Board level
• Review process included all team members throughout
• Baseline established of current service provision
• Extensive consultation with stakeholders and service users
• Identification of relevant national and local initiatives
• Examination of other service models
• Formalised report and recommendations with service development plan
• Feedback to all participants on outcomes of review.
Each team divided into working groups with specific objectives and a time plan. The whole team re-grouped at the interim stage and for final presentation of findings and development of proposals. The groups used a variety of methods both qualitative and quantitative, employing national tools when available or devising local audits approved by the hospice audit group.
Each review provided clear evidence of quality services with an identified plan for further development. Additional hidden benefits of a totally inclusive review included team building opportunities, skills development, a willingness to receive and act upon open criticism, a renewed interest in research and service development and a wider organisational understanding of each service and the challenges for each team. Due to the inclusivity of the process and a 'bottom up' approach to shaping services for future delivery, there was a much greater understanding for the need for change and ownership of this change. All of this was achievable through a hospice culture of support and a belief in the continual improvement of services.
Whilst reviewing services can be time consuming there are some real benefits in involving the whole team in this process.This approach has become accepted, and expected, practice within our hospice with each team now eagerly awaiting review.

PE 2.S271

Learning from early adopters

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Psychosocial problems and needs in palliative care deserve specific attention. Doctors and nurses are capable to notice the first signals of psychosocial problems, but they are not always able to recognise and treat specific psychosocial problems. Therefore, social workers could play an important role in psychosocial care for palliative patients. They are educated to understand how social factors, processes and changes can influence lives.
This fall a study, which focuses on social workers in palliative care, will be accomplished. The research question is: what are good examples of early and structural involvement of social workers in psychosocial care within the palliative care in the Netherlands and which recommendations for improvement can be extracted from these examples for all professionals involved?
This research will focus on how psychosocial care is organised around the patient. The researchers will search and describe five good practices in different settings: a general and academic hospital, a hospice, an elderly home and a home care situation. In each setting semi-structured interviews will be held with different professionals providing psychosocial care. Based on the interviews a case description will be written.
From these case descriptions several recommendations will be extracted for all professionals involved in psychosocial help and care. The definitive product will be a practical instruction that can be used to improve psychosocial care in the palliative phase.

PE 2.S272

The PIVOT project - Implementation of a new nursing role in healthcare institutions for specific patient groups

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Aim: To enhance a systematic approach to palliative care as a way of improving quality of care.
Methods: A new nursing role (PIVOT-nurse) is introduced in five care institutions participating in the project; for people with intellectual disabilities (2), psychiatric disorders (1) and nursing homes for the elderly (2).
Two nurses per institution received a five day training to act as a 'palliative care consultant'. The training was focussed on symptom management, decision making, coaching- and communicationskills.
The nurses play a connecting role between their specific field of expertise and palliative care services like consultation teams and hospices.
The PIVOT-nurses were assigned to a specific task for about 4-6 hours weekly, namely:
• to actively identify clients who need palliative care, in their workarea;
• to guide the team of caregivers involved in taking a pro-active approach in assessing care needs and problems;
• to promote the use of state-of-the-art methods, screening instruments and knowledge;
• to provide coaching, advice and support in the planning and coördination of care;
• to promote a timely consultation of a palliative care expert team when necessary.
Their functioning was monitored during and after a one year pilot phase using registrations of activities and patient variables and evaluation forms (likert-scale type).
Results: In the project the following results will be produced:
• a description of the PIVOT-function, including competencies required;
• an elaborate description of a five-day training course for the role of PIVOT-nurse;
• evaluative data concerning perceived contribution to quality of care (by april 2009);
• a model for implementation of the function in healthcare institutions.
Conclusion: Preliminary evaluations show that the implementation of the 'PIVOT-nurses' is feasible and regarded very positively by their co-workers.

PE 2.S273

Organization of palliative/hospice care in Poland according to the data from Ministry of Health Registry 2008

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Background: Palliative care in Poland is offered in various forms of health care institutions in which there are specific palliative care units. They include: home hospice, palliative/hospice day care center, residential hospice, palliative medicine hospital ward, palliative medicine clinic, hospital-based supportive teams of palliative care. Any health care institution may consist of one or more palliative care units.
Aim: The aim of the study was to review the

organization of palliative and hospice care in Poland in 2008.
Methods: The analysis of the Ministry of Health Registry of Health Care Institutions in Poland concerning palliative care units.The criteria used for analysis were:
1) type of unit
2) type of subject which founded the unit.
Results: According to the status in October 2008 there were 849 registered units which were offering palliative care in Poland. Almost half of them (413;49%) were delivering care at patients' homes, 263(31%) on the ambulatory basis, 162(19%) in residential hospices/ hospital wards and 11(1%) in the day-care facilities. 601(71%) from them were founded by individuals, companies, church, foundations and societes and only 248(28%) by public subjects (of national administration and / or local government).The majority of units were dedicated for adult patients (788; 93%) and only 61(7%) offered care for children mainly as home hospices (54 of 61; 88,5%).
Conclusions: Palliative/hospice care units in Poland are founded mainly as a private initiative. Among them home hospice and palliative medicine clinics are predominant. There is a need to develop hospital-based supportive teams and better palliative care for children.

PE 2.S274

Ambulatory routines in a unit of palliative care in Brazil

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The approach of outpatients in ours Palliative Care Unit, in Brazil, is available to the patients that have a better performance status (KPS), above 50%, and to the patients that have a worst KPS but living outside coverage area of our Home Care Service. During the first consult, the patients are attended by all the multidisciplinary team that will determine the patient's profile and their plan of care. In subsequent attendance, the patients will be consulted only by the professionals directly responsible for their needs, the frequency of return is around fifteen days. The caregivers are present consultations to receive information and explanations to your questions. Drugs, materials to dressing, oxygen and other items that may improve the patient's quality of life are available. The ambulatory gives support to an average 600 patients with about 80 new patients by month. In our study, we observed those patients who initiated the ambulatory accompanying from January 2008 to September 2008. The monthly average admissions in our facilities were 77,8 with a global rate of 54,9% of male patients. The median of age is 61 years and the average of the KPS are above 60%, representing 75% of studied population. The most common tumors are: head and neck (34,3%), lung (12,8%) and cervical (8,7%). The most frequent sites of metastatic disease are lung (9,7%), liver (6.7%) and brain (3,8%). At the first consult, about 44,6% of patient presented pain, with an average verbal numerical scale (VNS) under 5, and about 40,9% of patients were using opiates previously. The most common symptoms are: constipation (51.5%), hyporexia (46.2%), asthenia (31.8%) and fatigue (18.4%). Most patients have at least 2 symptoms at the time of admission. The aim of ambulatory set of palliative care unit is to offer an accurate multidisciplinary assistance in agreement with our patient profile for the adequate symptom control and improvement for the patient and family/caregiver's quality of life.

PE 2.S275

Benchmarking length of stay (LOS) in acute care palliative medicine

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Aim: Determine length of stay (LOS) benchmarks in acute care palliative medicine as.
Method: A retrospective review of the institution's computerized data base involving the All-Patient Defined Diagnostic Related Group (APR-DRG), palliative medicine discharges by physician from 2001-2007. This data was compared to 1/1/08-8/31/08.
Results: From 2001-2007, there were 5546 discharges, mean LOS 9.7 ± 7.3 with a Palliative Medicine target benchmark of 9.2 (versus national average of 6.9). Opportunity days (extra days patient stayed compared to national standard) decreased from 15,488 to 2734 when the 7-year LOS benchmark was used. Mean 2008 LOS was 10.5 ± 7.9 with a palliative medicine benchmark of 9.7 (national average 7.3). Using this benchmark, opportunity days decreased from 1857 to 451. Opportunity days for the 5 most common APR-DRGs in the 7-year period also decreased: respiratory malignancy 71 (from 804), digestive malignancy 212 (from1178), musculoskeletal malignancy 45 (from 984), hepatobiliary/pancreatic malignancy 43 (from 482) and lymphoma 111 (from 533). Using same benchmarks, 2008 opportunity days decreased for the above APR-DRGs: respiratory malignancy -23 (from 17), digestive malignancy 22 (from 90), musculoskeletal malignancy 62 (from 136), hepatobiliary/pancreatic malignancy -4 (from 20), and lymphoma 42 (from 65).
Discussion: There is no LOS benchmark for acute care palliative medicine. Comparison defaults to a national average from the general medical/surgical population which is significantly shorter. Admissions to an acute care palliative medicine unit is skewed to a sicker and more complicated population needing more complex medical/psychosocial care with longer length of stay.
Conclusion: LOS benchmarks can be derived from an existing data summary that more accurately reflects the complex care in palliative medicine and reflects a longer length of stay.

PE 2.S276

A multifarious approach to promoting palliative care in Greece for patients with neuromuscular diseases

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MDA Hellas (Muscular Dystrophy Association of Greece) was formed in 2000 in order to improve the quality of life of patients with neuromuscular diseases. Throughout the years our primary concern has been to address the unique challenges in the care of patients with neuromuscular diseases and have been actively promoting palliative care.
Our goal has been to create a system of support and networking by addressing the scientific community, professionals working on the field, the patients, their families and the community at large. Through an international collaboration with the Bioethics Institute at John Hopkins University we have been able to explore different techniques used worldwide and expand our scope of activities.
With this poster presentation our goal is to present the challenges and activities we have made in the past years in developing palliative care for patients with neuromuscular diseases.
More specifically our patients, parents and sibblings support groups, our integrated art groups - theather and painting-, our sports activities for patients, our public awareness program for neuromuscular diseases for preschool and elementary school age children, our adult volunteer program and our scientific program will be addressed. Furthermore, we will present the MDA special clinics developed (three so far throughout Greece) in order to be able to foster an interdisciplinary approach for patients with neuromuscular diseases.

PE 2.S277

Integrated care in palliative medicine - Cooperation between a university hospital and a hospice association

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Background: In Germany, different models for Integrated Care Programmes in palliative medicine have developed over the last few years. In Munich, a cooperation was established in April 2007 between the AOK (largest local public health insurance), the Interdisciplinary Center for Palliative Medicine (IZP) of the University Hospital and the Christophorus Hospice Association (CHV).
Methods: Registered patients with particularly severe symptom control and/or psychosocial problems are attended by a Palliative Care Team (PCT) composed of an experienced physician from the IZP, as well as specialized palliative care nurses and social workers from the CHV. The PCT offers a consult service for all health care professionals involved in the patient's care and can also visit patients at home or in the nursing home. The PCT decides on a case-to-case basis which team members to involve for each patient. For acute crises, a 24/7 on-call service is offered.
Results: In the first 18 months of the cooperation 139 patients could be included in the Integrated Care Programme (71male, average age 69 yrs, range 26-100 yrs), of whom 110 have died so far. The average duration of care by the PCT was 61 days (range 3-420 d) for deceased patients, and 145 days for alive ones. 82% of patients had oncological, 11% neurological and 7% internal medicine diagnoses. Due to worsening of symptoms, 30% of the patients required admission to a palliative care unit, while 13% were admitted to an inpatient hospice. 50% of the deceased patients died at home, 17% in an inpatient hospice, 25% in a palliative care unit, and 8% in an acute medical unit.
Conclusion: The cooperation between a University Palliative Care Unit and a Hospice Association has proven to be a successful and enriching experience for both sides. This model provides a good basis for the implementation of Palliative Care Teams within the new German framework of "Specialized Community Palliative Care Services (SAPV)".

PE 2.S278

Access to the knowledge base for supportive and palliative care in Europe: Comparative analysis of national online knowledge services

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Aims: Access to the best current knowledge in supportive and palliative care is a basic requirement if care is truly to be evidence-based. England has hosted an online specialist library website for professionals in supportive and palliative care since September 2004. Other such initiatives have been under way in other countries worldwide. However, there was no clear picture of the level of development of such services internationally. To gain an insight into best practice across Europe we compared those national websites in EU member states which seek to help supportive and palliative care professionals access and use the best current knowledge.
Methods: We conducted a study of the provision of national online medical and health knowledge websites in supportive and palliative care across the European Union's 27 member states. The study was in 3 stages:
(1) Systematic literature review of relevant bibliographic resources in medicine, health, social care and information science.
(2) Internet searches gathering core data on each state.
(3) Development of a simple typology of national health knowledge service websites illustrating a 4-stage spectrum of development.
Results: A table was assembled showing the characteristics of online national knowledge services across the EU. Data collected showed wide variations in the level of provision for professionals in this field.
Conclusion: There are inequalities in the quantity and quality of national knowledge services available to health and social care professionals in supportive and palliative care across EU member states. This may be due to a number of variables including differences in national government policies, economic development, culture and infrastructure. The potential for free movement of the palliative workforce across the EU may not therefore be matched by a similarly free flow of the best current knowledge to wherever it is needed.

PE 2.S279

Do geographic accessibility and deprivation levels predict a hospice death?

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Background: Previous research has shown that inequalities exist in the geographic accessibility of inpatient hospices across England. Accessibility is highest in major conurbations; rural areas have poor access.
Aim: To determine whether geographic accessibility, deprivation, gender, age and region are predictors of a hospice death.
Methods: Hospice 'accessibility scores' were derived using a Newtonian distance decay model that analysed 6.5 million road network drive times between 189 inpatient hospices and 34,378 localities. Utilisation ratios contrasted hospice cancer deaths against all cancer deaths, by: region, hospice accessibility and

deprivation levels, urban-rural typology and demographic variables. Correlations examined possible linear relationships between accessibility, deprivation, and the proportion of hospice deaths per locality. A multivariate binary logistic regression analysis, undertaken on 378,482 anonymised adult cancer death records (2003-05), modelled whether access, deprivation, age, gender and region influence the likelihood that a patient will die in a hospice.
Results: Cancer patients from across society die in hospices. Once effects attributable to other variables are accounted for, the odds of dying in a hospice in England are significantly greater for cancer patients from the most accessible decile of localities than for those from the most inaccessible decile of localities, though a notable distance decay effect is seen in the least accessible rural areas. Patients living in the most affluent decile of localities are significantly more likely to die in a hospice than are those from the most deprived decile of localities.
Conclusion: Clear gradients in the likelihood of a hospice cancer death, by decile of accessibility and deprivation, are revealed. Further research examines who dies in hospices.
Funding: ESRC CASE studentship PhD award.

PE 2.S280

Specialist nurses experience of clinical skills training to support service development

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Aim: Debate surrounds development of clinical examination skills taking nursing roles into traditionally medical areas. NHS workforce and care delivery redesign, combined with the shortage of medical staff, economics, European Working Times Directives and the GP out of hours contract give opportunities for nurses with extended clinical skills. We aimed to record the experience of senior nurses learning medical examination skills.
Method: We purchased a 3-day traditional medical model MK Update clinical examination skills course with one tutor supported by our doctor. Attendees were examination models. On day 3 attendees were given a questionnaire on attitude, experience, content and motivation to continue developing skills.
Results: 16 Clinical Nurse Specialists (14 palliative care, 2 cancer) attended.14 replied (87.5%). Nurses wanted to expand knowledge and skills, improve history taking and fulfil service development roles. Concerns were: forgotten anatomy and physiology; examining colleagues and being examined; taking on medical roles without training; unknown expectations and discovering their own pathology.
They felt relaxed, intellectually stimulated and challenged. The pace overwhelmed them at times. Despite apprehensions and anxiety they enjoyed learning new skills. Best things were enabling teaching, refreshing forgotten knowledge and feeling a liver! Worst was being examined but this gave insight into patient experience. The information in three days was onerous. As lone practitioners they doubted further skills use so were keen to join a learning set.
Conclusion: The changing NHS requires role development. Responses showed clearly the apprehension and fear of learning new skills but also enjoyment and enthusiasm for doing so with support. Nurses identified that these new skills would only be helpful to their role if they were competent in their use, supervision and practice were required. A longer less intensive course may be better.

PE 2.S281

A community-based model is effective for implementing Physicians Orders for Life Sustaining Treatment (POLST) paradigm

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Problem: A limited awareness & miscommunication of patients´ wishes for life sustaining care across the continuum of care.
Hypothesis: Using a community based approach to implementing Physicians Orders for Life Sustaining Treatment (POLST) paradigm in the Inland Empire, located in Southern California, will increase awareness and fulfillment of patients´ wishes for life sustaining care.
Processes to resolve problem: Working with a broad cross section of the Riverside County community, the Inland Empire Palliaitive Care Coalition (IEPCC) developed a community-based model to implement the POLST paradigm. It incorporated physicians, nurses, hospice organizations, skilled nursing facilities, chaplains, and concerned community members. The IEPCC´s approach focused on
(a) identifying potential patients and families benefiting from POLST,
(b) working with primary care physicians in utilizing POLST as a complementary document to the advance directive, and
(c) developing educational campaign regarding POLST to easily identify and execute POLST.
Outcomes: Since its implementation in 2007, utilization of POLST increased to over 10000 patients and is in use by 15 facilities in Riverside County. The observed benefits of the POLST include
(a) greater ease of discussing end of life care with patients and families,
(b) increased awareness of palliative care based treatment, as well as
(c) fulfilling wishes across continuum of care.
The success of this local initiative, as well as that of several other community coalitions, led to the state wide acceptance of the POLST. In August 2008, the POLST form was signed into legislation as the standard for communicating patient´s end of life wishes in California.

PE 2.S282

The partnership between a NGO and a company: A successful story

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Almost 20 years after the 1989 Revolution, the palliative care services in Romania continue to be provided primarily by NGOs. In order to develop palliative care services, the community involvement and financing are very important. Creating a partnership between a NGO and a company, for which the corporate social responsibility is a way to improve the people's quality of life, has been a way in developing and delivering palliative care.
The program has taken place in 2007 in 4 big cities of Romania (Bucharest, Brasov, Oradea and Bacau) and its aims were to provide innovative palliative care services (respite-care, support-groups) and to continue those already existing for the persons in need (home visits, hospital palliative care, activities in day-centers and in-patient units). After one year, 734 adults and 225 children have received palliative care services through 1,413 hospital consultations and 10,057 home visits. The caregivers were involved in support groups and 31 different leaflets were created for them. Also, they were sustained by the new respite activities. Volunteers as the community representatives were involved in providing some of the palliative care services.
The involvement of the company has given the opportunity to the palliative care providers from 3 centers (Bucharest, Brasov and Oradea) to diversify their offer of services for the people struggling with an advanced illness and their families. In another center (Bacau) palliative care services have been newly created and developed. The new team was linked with existing ones as a network of palliative care professionals.
The results of the first year have led to a continuation of the partnership for the next year, in this way the number of people having access to the palliative care services has increased.

PE 2.S283

Palliative care in Ukraine - Present condition and prospects for development

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Introduction: In Ukraine there is no state legislation or proper medical standards for palliative care. Based on data provided by Ukrainian organizations stationary units located in 13 of 26 provinces are the only form of palliative care.
Aim: Identification and assessment of the present condition of palliative care in Ukraine. Assessment of options of palliative care development in Ukraine.
Methods:
1. Implementing 2 international projects financed with grants provided by the Polish-American Freedom Foundation in cooperation with palliative care organizations in Ukraine.
2. Consultations, counselling and cooperation of Polish experts with the Ukrainian partner aimed at elaborating: legislative legal acts for the nationwide Ukrainian laws and proper standards of palliative care procedures.
3. Analysing data provided by WHO and the Ministry of Heath in Ukraine.
4. Analysing data provided by partner organizations.
Results: 12 people form Ukraine participated in two 7-day internships organized in Poland. 5 Polish specialists visited Ukraine, and 320 altogether participated in 5 training courses and consultations organized in Ukraine.
Problems reported: No procedure standards or legal acts which could allow for palliative care development, insufficient funds, no home care provided, a limited access to opioids.
Conclusions: The way to develop palliative care in Ukraine is to:
• Introduce legal acts governing palliative care functioning and medical standards;
• Provide financing sources: state budget funds, other: funds collected by non-governmental organizations (foundations, associations, sponsors);
• Introduce training courses for staff working at hospicesand staff employed in other specialization fields: internal medicine specialists, general practitioners, oncologists, social welfare employees;
• Develop home care;
• Provide an easier access to opioids;
• Change social stereotypes.

PE 2.S284

The general public's experiences, perceptions and expectations of palliative care in Romania

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Aims: This study aims to explore the general public's experiences, perceptions and expectations of palliative care services in Romania.
Methods: A questionnaire survey was applied to a stratified random sample of the population, who were interviewed at home by an independent market research company. Experiences, perceptions and expectations of palliative care were assessed. Individuals were questioned about experiences in general of caring for people with advanced illness, how such care might be appropriately addressed and how the community and the state healthcare system could be involved in improving services available for terminally ill patients.
Results: 2483 individuals completed the survey. 12% had personal experience of caring for someone in the terminal stages of illness and 9% reported another member of the household having had such experience. 18% of carers had no extra support and bore the burden of care alone. 54% of respondents felt that terminally ill patients should be cared for at home, 30% in a specialised centre and less than 1% in hospital. If they had to care for a terminally ill patient at home, 70% of respondents identified the need for medications to relieve pain, 55% for qualified medical staff to visit regularly and 35% for trained professionals to discuss with the patient and family about the illness and prognosis. 61% stated that the public health system should invest money to relieve suffering in patients with advanced disease, 33% recognized that these patients' needs could not be completely addressed with public funds and that everyone in the community should support specialist centres with donations.
Conclusions: This study illustrates the general public's experiences, perceptions and expectations of palliative care in Romania and highlights the preference for palliative care either at home or in a specialist unit. These findings will be used to influence national health policies regarding the development of palliative care services.

PE 2.S285

Anticancer therapies in palliative care settings? A case series

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Introduction: Anticancer therapies (ACTs) gain

attention in specialized palliative care (PC) institutions. Their effects on symptom control are increasingly documented. The use of ACT, preceding assessment, response on symptom burden, overall clinical outcome, psychosocial co-factors, patients´ wishes, treatment related morbidity, time spent for application and surveillance procedures, and financial burden are still to be described.
Methods: Over a two year period, all in- or outpatients eligible for and treated with ACT on our PC unit were interviewed, clinically assessed (rating scales and MIDOS) and further observed. Clinical chart evaluation, semistructured interviews with the responsible PC physician and financial calculations by the clinic pharmacy provided further information.
Results: To date, 8 patients have been evaluated. In 5 patients, ACT showed no associated clinical or subjectively reported benefit. One patient perceived an impressive, but very short-lived improvement of dyspnoea (6 days). In 2 patients, a relevant tumour response with improvement of palliative outcome criteria could be observed in a treatment interval lasting 5? months (Euro 14.879,- therapy related costs) and 7 months resp. (Euro 14.418,-). No significant toxicity was reported. Decision criteria were rapid disease progress (7/8), patients´ demands (7/8), and positive experiences in similar previous situations (6/8), whilst treatment costs or patient´s age were no relevant decision criteria.
Discussion: In a specialized PC setting, ACTs are infrequently applied. Profound symptom control could be documented in 2 cases, which was related to novel targeted therapies. The economic burden approaches values that are considered to be ineffective in costs in life-years gained studies, besides the individual procedural expenditures. Therefore, the use of ACT in PC should be restricted to highly selected patients, comprising novel targeted therapies and their response prediction criteria.

PE 2.S286

Facilitating success: A review of literature about the contribution of 'champions' to service improvement programmes

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Background: This literature review was commissioned by the Programme Director for the NHS End of Life Care Programme in response to findings of the programme's national evaluation: that successes were attributed often to the contribution of 'champions' involved in the programme.
Aims: To examine the contribution of designated facilitators to a broad range of improvement programmes, to explore whether / how they help generally to promote success.
Method: A semi-systematic review using CSA Illumina and MetaLib resources. Inclusion criteria included 'hits' in keywords and/or abstracts published in English from 1998 to 2008 (MetaLib) and 2003 to 2008 (CSA Illumina). Search terms (with Boolean combinations): champion*, facilitat*, advoca*, spokes*, (pro* lead), sustain*, long term, impact, outcome, effect*, change, benefit. After criteria attrition - firstly scanning results for general relevance, then examining abstracts for clarity and content of specific relevance, and removal of duplicates - 104 papers remained for detailed scrutiny Findings.
96 of the104 programmes are identified as effective, with details provided about the extent or type of impact and factors influencing the successful outcomes Success is linked specifically to the facilitator/s in 53/96 effective programmes. The facilitators´ contributions are linked variously to their input; functions and roles; personal characteristics; level or locations of work, and from where recruited. In 28 effective programmes, the contribution of the facilitator/s is substantial, variously described as a crucial, main or important factor. The paper provides detail of the substantial facilitator contribution to nine effective UK-based programmes.
Conclusions: The findings strengthen applications for End of Life Care Strategy (July '08) funding to be used on employing facilitators to lead ongoing work to improve access to and quality of end of life care.
Main source of funding NHS End of Life Care Programme.

PE 2.S287

How to integrate palliative medicine into medical oncology: Analysis of a stepwise realisation of the ESMO Designated Center Program at an academic teaching hospital

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Introduction: The European Society for Medical Oncology elaborated a program for the integration of palliative medicine (PM) into medical oncology (MO). A key element of this project is the accreditation of a department for Medical Oncology as a Designated Center if a catalogue of 13 criteria has been realized.
Aims: to analyse the process of a programmatic integration of PM into MO within an academic teaching hospital
Method: a retrospective analysis of the process with regard to its personal, structural, organizational elements within a Dep. Medical Oncology during the last 5 years
Results:
Personal aspects: At the beginning, all members of the staff underwent additional training in communication skills as well as in pain and symptom control. One third of the staff inculding dietician, physiotherapists and psychooncologists underwent further education in PM, at least one physician and two nurses per ward obtained a degree in PM.
Structural aspects: The routine use of validated instruments for the evaluation of pain and other symptoms as well as for the need of psychosocial support become obligatory. Written guidelines for the treatment of pain, respiratory and gastrointestinal symptom were given. A formular for documentation of patient´s living will had been introduced as well as a documentation flow for palliative sedation.
Organizational aspects: A group of volunteers (out-patient hospice) as well a ambulant palliative care network has been founded. A round the clock hotline has been installed for palliative emergency cases. A multidisciplinaray PM team with weekly conferences has been created.
Conclusions: The integration of PM into MO is an ongoing process requiring a systematic and stepwise approach. It optimizes the quality of medical treatment and strongly contributes to patient´s, relatives´ and staff´s satisfaction.

PE 2.S288

Telephone triage in specialist palliative care

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In light of the national agenda for the modernisation of healthcare services and for high quality palliative care to be made available and accessible to all patients with life limiting illness the challenges for specialist palliative care providers are immense.
In order to keep pace with change and meet the many and varied challenges it has become increasingly necessary for providers of specialist palliative care to break with tradition and look outside of the box to find ways of increasing service provision with their limited resources.
Saint Francis Hospice made a ground breaking move by establishing a specialist telephone triage service to facilitate a comprehensive structured specialist palliative care assessment; to provide support and specialist advice to patients who have specialist palliative care needs but do not wish to be supported by a home visiting service; to support immediate referral to appropriate hospice service and to provide specialist advice and support for professionals, patients and carers.
The adapted model of the Support Team Assessment Schedule (STAS 1989) is used as an assessment tool, and this facilitates comparison of telephone assessment outcomes. The introduction of a Triage service has successfully reduced waiting lists by providing a flexible and responsive service appropriate to the patients needs at the time of referral. Patient satisfaction questionnaires re-enforce its success.
We are all challenged to have confidence and courage to take the very best of palliative care and make it available to a wider reaching group of patients without diluting or compromising our services. Using models familiar in other specialities, adapted to our patient group, we have been able to modernise and improve our service. Telephone triage is an exciting innovation and an indisputable asset to modern day specialist palliative care provision.

PE 2.S289

Inventory of the organisation of palliative care in seven European countries

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Aim: To compare the organisation of palliative care in seven European countries (Belgium, France, Germany, Poland, Spain, The Netherlands and The United Kingdom) in an EU funded Project: 'Best practice in Palliative Care in Europe'.
Study design and methods: A questionnaire has been developed by the participating researchers with open questions about the organisation of palliative care (national health care system, laws regarding palliative care and financing). In the summer of 2008 a literature search was performed in each country, including grey literature. The questionnaire was filled in by the researchers based on this literature review and sent to national experts in the field of palliative care such as professors in palliative care, professional healthcare providers and policy makers to confirm and to give comments on the data of their own country. With this information a definitive overview of the organisation of palliative care in the seven countries was made. We compared the collected data of the seven participating countries.
Results: We were able to describe similarities and differences in the organisation, the legislation and financing in palliative care in 7 European countries (Belgium, France, Germany, Poland, Spain, the Netherlands and the United Kingdom).
Conclusion: There are many differences between European countries in the organisation of palliative care. We were able to describe similarities and differences in seven countries. All results will be presented at the EAPC conference in Vienna.

PE 2.S290

Setting complementary therapies in a public hospital and a private clinic: Process of organization of services and permanent auditing of results

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Complementary therapies (CT) are relevant part of palliative care. They can help to control pain among other symptoms and may improve quality of life to both ambulatory and in bed chronic and acute patients in hospital settings. To set complementary therapies in public hospitals and private clinics implies a process of organization of services and permanent auditing of results.
The aim of the study is to report the organization process of CT in a public hospital and a private clinic (Mexico City) and the auditing of improvement in quality of life for chronic and acute patients. To measure benefits Edmonton Functional Assessment Tool (EFAT), Visual Analogue Scale (VAS) and Palliative Outcome Scale (POS) were applied. Data evidences that Clinic Reflexology, Reiki and Indian Head Massage improve quality of life with regard to pain and general well-being.
Conclusions are that complementary therapies are useful means to provide palliative care for chronic and acute patients; however, it implies to assure institutional acceptance and support to maintain and expand the services. Auditing benefits are important tools to get it.

PE 2.S291

To be yourself until the end. Could well-organized palliative services contribute to this ambition?

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At the end of his life we are in many ways fragile and vulnerable. With the healthcare system in the Czech Republic patient may easy loose himself. Renowned specialists attend to individual parts of the body; the patient receives various reports which often contradict themselves and he doesn't have anyone who would put together some meaningful message, which would comprehensibly tell him what he needs to hear: how to use the short time he has left, how to deal with his life in his own way. Instead, he looses himself little by little and is transformed from a subject into an object. He is literally portioned up into parts which, just as the specialists themselves, do not communicate with each other (illustration).
Palliative care does not offer the alternative of only one person who has time, looks into one's eyes and holds the ill person's hand. It again offers the system of specialists. Will not the patient be portioned up once again, though perhaps more kindly? If we wisely organize palliative service for the patient we must accept the fact that we all have different wishes and needs - however we all want to remain ourselves. Freedom must therefore stay at the patient´s side, as much as possible. Palliative care must not offer services directively but present them as a comprehensible and open offer. It offers ways that a person and his loved ones can, but do not have to choose roads, which he is still able to pursue.
We conceive our services so that they complement each other and offer the patient what he needs in each phase of his life. The decision is always up to the patient and his loved ones. This is why each service (consulting website, mobile hospice, club for bereaved, library etc.) offers room to choose another service and sensitively invites the person to make this choice (illustration of communicating services). Mutual continuity and cooperation of services is necessary for a person to remain himself, to be who he was and who he wants to be.

PE 2.S292

Supporting clinical teams through group reflective practice

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Every nurse is required by the NMC Code of Professional Practice to be a reflective practitioner and to regularly reflect on their clinical practice. However, implementing individual clinical supervision for all clinical staff is rarely feasible, financially or practically, due to the large numbers of staff involved.
A survey of clinical staff, conducted at Saint Francis Hospice in 2006 aimed to establish views on clinical support and stress. Results highlighted that clinical staff felt lacking in support and clinical supervision and would welcome a regular opportunity to reflect on their practice.
In response, a new initiative of mandatory, group reflective practice was implemented to develop group reflective practice across all clinical teams. It was felt to be the most effective way of providing appropriate clinical support to a large number of staff and to encourage ongoing professional development. The initiative enabled us to bridge the gap in our provision of clinical supervision for staff in Agenda for Change Band 5b and below and provide enhanced support through reflective practice.
Reflective practice sessions of an hour long are held bi-monthly throughout the year. The sessions are mandatory and monitored as part of the appraisal process. Group members are supported in bringing clinical issues, development issues, and communication challenges to discuss in a safe and protected environment.
Feedback from both attendees and facilitators continues to be extremely encouraging. The end of first year audit and a repeat clinical staff survey has enabled us to analyze and evaluate effectiveness of the supervision and give us confidence that in providing appropriate support for our clinical teams we are in turn facilitating their provision of specialist palliative care of the highest quality.

PE 2.S293

The consultation-hour for the ambulant patients as an effective form of palliative care

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The Palliative Care Department in Unna exists since 1998. To extend our offer for a better symptome control for the ambulant patients, we organized in 2002 the consultation-hour, for which great demands are made on.
The aim of this investigation mainly was to see to what extend is this form of the palliative care in use and what results could be achieved with the help of such supplementary offer in palliative patients. Another goal was to analyze the statistic as well as to observe general tendencies as to predict the advantages of this institution.
During six years we cared 241 patients in the palliative care consultation-hour. We explored following criteria: the reason(s) to contact us in the consultation-hour, duration of the consultation, strategy and measures taken in the consultation-hour, effectiveness of the therapy recommended (for example by control of the symptoms conducted in the regular home visits). Results of positive changes in the treatment of the ambulant patients could be gathered.
Conclusions:
1. The consultation-hour seems to be a good possibility to get more intensive contact to the patient and his family.
2. The personal contacts and the interdisciplinarity in the consulation-hour is a good precondition for better symptom control in future.
3. At the group of the ambulant palliative patients we can see that due to our contacts in the consultation-hour the time spent at home can be elongated.

PE 2.S294

Administration of Gabapentin as co-analgesic drug for bone pain management in patients with advanced cancer

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Objectives: Assessment of "Gabapentin" co-analgesic effect in patients with residual pain, in case of bone tumor lesions.
Methods: 99 patients with malignant growths, between 18-80 years (Average age-52,4), divided into 2 groups A (main -64) and B (control-35). Cancer localization was as follows: Group A: breast 26, lung 15, bone 5, prostate 7, unknown location 5, and 6 other; Group B: breast 23, prostate 3, colorectal 3, renal 2 and 4 other. Patients with severe pain (33 in A and 21 in B) received opioids and patients with moderate and mild pain (31 in A and 14 in B) received non-steroid anti-inflammatory drugs. Pain was assessed by Visual Analogy Scale (VAS). Group A - the mean point of pain was 6,0 by VAS, group B (correspondingly) - 6,4. Despite analgesic therapy, average residual pain was 3,1 (group A) and 3,0 (group B) by VAS. All patients from group A received Gabapentin during 15 days: I day-21.00 300mg.; II day-9.00 and 21.00 300mg.; III day-9.00, 15.00 and 21.00 300mg. Patients in group B received Placebo instead of Gabapentin in the same regimen.
Results: Pain management results:
Group A: Reduction of residual pain - from 3,1 to 1,0. At the end of research, 20 from 38 patients with mild pain had no pain; 8 from 26 patients with moderate pain, had no pain and 18 had mild pain. Only in 4 patients the point of pain didn't change.
Group B: Reduction of residual pain - from 3,0 to 2,6.
Finally: patients in group A have positive results: residual pain was redused by 2,1 points (P<0,05). In group B residual pain was redused (0,4 points). Most frequently revealed side effect of Gabapentin was sadation. 4 patients had deep sedation, 2 patients-diarrhea, and one case of euphorea, hadache and insomnia.
Conclusion:
1. Gabapentin reduced residual pain up to 2,1 points by VAS; nearly no pain reduction by Placebo (0,4 by VAS), main side-effect was sedation;
2. A flexible dosing approach appears appropriate to ensure patient compliance and treatment success.

PE 2.S295

Ketamine in the treatment of cancer pain - A systematic review

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Ketamine is increasingly being used as an adjuvant to opioids in the treatment of cancer pain, mainly without evidence based recommendations regarding dosages and indications. We conducted a systematic review to examine the available evidence of using ketamine in the treatment of cancer pain.
A limited systematic review including randomized controlled studies, controlled clinical studies, and case reports was performed. Studies were identified by a database search which used the Cochrane Library (Issue 3, 2008), OvidMEDLINE (1990- 2008 week 40), PubMed (1985- 2008 week40) and Embase (1988-2008 week 40), by using the operators „Ketamine AND Cancer AND Pain". Additionally reference lists from review articles and already identified papers were hand searched. All studies and case reports which used ketamine for the therapy of cancer pain in adult patients were included. Four randomized controlled studies, 6 controlled clinical trials, 2 chart reviews and 16 case reports including 20 patients in total were identified. We found evidence grade I for the use of oral, epidural and intrathecal use in three studies with the indication 'neuropathic pain', 'terminal' or 'refractory cancer pain'. The studies included between thirty and 48 patients. Overall in all studies, the most common application is the intravenous way with dosages ranging from 1-15mg/kg per 24 hours. Other common applications are the oral use of ketamine in dosages between 1 and 1.5 mg/kg per 24 hours and the subcutaneous application of 0.1-1mg/kg ketamine per 24 hours. We found no clear evidence for the dosages and indications.
Throughout all studies and case reports show that ketamine provides an analgesic effect on cancer pain. However randomized controlled trials with large numbers of participants are still needed to provide evidence for the dosages and indications of ketamine's use in cancer pain.

PE 2.S296

Intractable abdominal pain and discomfort in patients of Chronic Liver Disease treated by corticosteroids

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Background: Hepatocellular Carcinoma (HCC) and Chronic Liver Disease (CLD) are relatively common in our region because of high prevalence of hepatitis viral infection B and C. One of the Palliative care needs of these patients is abdominal pain. There has been data on Tender malignant hepatomegaly pain responding to Corticosteroids. However, there is reluctance to use steroids if the pain is due to disease related to viral hepatitis.
Aims: To observe the response of abdominal or Liver capsule pain in patients with Chronic Liver disease secondary to viral Hepatitis when the disease itself is incurable.
Patients and methods: Prospective study of 20 consecutively admitted patients with CLD and HCC in our liver ward over a 4 months period.
Results: Out of 20, there were 16 males and 4 females with an average age of 58.5 years (range=45 to 70). All had Ultrasound scan findings suggestive of HCC and CLD. 2 patients had a positive serology for hepatitis B s Antigen, 2 had a history of heavy alcohol intake, 3 had no known risk factor for liver disease and the remaining 13 patients had serology positive for hepatitis virus C. These 15 patients were included in study. 2 patients were later excluded as they had Ascites as a possible cause of their Abdominal discomfort. Pain was recorded by Visual Analogue Score (VAS - 1 - 10, with 0 being no pain). 13 / 15 started Dexamethasone orally at 2 mgs tds as they had no relief on full pain management at their consultant physicians' discretion. Pain was assessed by measuring VAS after 1 week. 11 / 13 had some response with 8 / 13 observing complete relief (VAS - 0). 3 / 13 had partial relief with VAS dropping by 5. 2 / 13 had no relief with stable VAS. No change in the patients' disease status was observed over next one month.
Conclusion: Abdominal pain / discomfort secondary

to incurable Chronic Liver disease due to Viral Hepatitis responds to Corticosteroids in the comparable way malignant Liver capsule pain.

PE 2.S297

Intermittent subcutaneous opioid administration: A safe, effective, and cost-saving strategy for the management of cancer pain

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The vast majority of cancer patients have pain and opioids are its mainstream treatment. When the oral route is unavailable, the most common alternative is the expensive continuous intravenous infusion.
Aim: To determine the safety and effectiveness of a less expensive treatment modality for cancer pain management, the intermittent subcutaneous(ISC) opioid administration.
Methods: Retrospective review of 552 consecutive admissions to a palliative care unit, collecting data for all patients who received parenteral opioids. Information about demographics, injection sites and administered opioids were reviewed from all patients receiving ISC. Costs per milligram were determined and corrected according to relative potency to morphine. ISC was considered successful if discontinued in favor of the oral or transdermal route, or continued until death. All patients used the Edmonton Injector, an inexpensive mechanical device to deliver ISC opioids.
Results: 352/552(63%) admissions required parenteral opioids, and 301/352(86%) used ISC. 53% were female, mean age(range) was 61(19-97) years, and the most frequent diagnosis were thoracic(28%), gastrointestinal(18%), urological(11%), and breast(11%) cancers. The success rate was 88%(266/301). The median(interquartile range,IR) duration of ISC was 11(5-19) days, number of sites was 1(1-2), and mean(standard deviation) site duration was 8(11) days. The most frequent site was the arm(61%). Common reasons for site change were local redness(20%), bleeding(8%), and leakage(5%). Side effects and site duration did not significantly correlate with site location or opioid. The median(IR) potency-corrected drug cost was CDN$2.02(0.77-4.54) significantly lower for methadone, CDN$0.27(0.06-0.32).
Conclusions: ISC opioid administration is a safe, effective, and inexpensive cancer pain treatment, being particularly important in financial resource-scarce areas.
Financial support: Pall. Care Rehab. Med. Dept. M.D. Anderson Cancer Center.

PE 2.S298

Development of an electronic observational pain scale

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Pen-paper observational scales have proven to be useful to monitor pain, but have also a lot of disadvantages. The aim of this study is to present and examine the advantages of an electronic observational pain scale. The pilot study (approved by a medical ethical committee) took place in a specific geriatric centre. Patients are included when they're bedridden and have limited ability to communicate verbally. The caregiver has to objectify pain by means of a behavioural observation scale. Their usability is often limited, they are time-consuming because of their length, difficulties in calculating scores, and post processing required to evaluate the pain evolution. Also the exact timing of the indicators can't be recorded in real-time, and thus complex timing patterns can't be evaluated. Each patient was tracked for 6 random days, in which 6 assessment sessions were performed at clinically interesting moments, after an informed consent was signed by a relative.
As input for the electronic scale, 3 valid and reliable scales are chosen: the Pain Assessment Checklist for Seniors with Limited Ability to Communicate, the Discomfort Scale - Dementia of Alzheimer Type, and the Faces Pain Scale Revised. The electronic device (a tablet PC with a touch screen) allows the caregiver to record indicator events, such as frequency and duration, as they occur in real time. The scores are calculated automatically. The digital information is stored in a database, improving administration and allowing database applications. With the advantages of the electronic device, nurses will be stimulated to perform more frequent pain measurements. A more adequate treatment can be provided with the knowledge of a more accurate pain level. Advantages of this electronic observational pain scale are an increased usability, less time-consuming and inclusion of complex timing patterns. This will lead to a more accurate measurement of pain, a more adequate treatment and thus improving quality of life.

PE 2.S299

Prolonged-release oxycodone/naloxone is very effective and tolerable in treatment of cancer pain

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Research aims: A prolonged-release (PR) oxycodone/naloxone combination reduces se-vere cancer pain and additionally prevents/ reduces side effects such as opioid-induced constipation. A multicentre observational trial studied the efficacy and tolerability of oxy-codone/naloxone PR in broad practical use in more than 1.100 patients.
Study design and methods: In the 4-week observational study, data was recorded at four assessment visits, the 2nd of which was optional. Patients received oxycodone/naloxone PR at the initiation visit. Efficacy of oxycodone/naloxone PR was measured by changes in pain intensity (NRS, 0 -10 no pain - worst imaginable pain). Bowel function was documented using the bowel function index, a newly validated questionnaire for assessing opioid induced constipation. Quality of life was recorded using the overall score (0 - 70 = no limita-tion - worst limitation) for the 7 usual parameters. At trial completion, doctors and patients assessed efficacy and tolerance. Doctors additionally assessed tolerability of oxy-codone/naloxone PR compared to previous treatment.
Results: 1.178 patients included in the study suffered severe or very severe cancer pain. Average pain intensity reduced significantly. Bowel function and quality of life improved markedly. In the final assessment, the vast majority of doctors and patients assessed effi-cacy and tolerance as "very good" and "good", the vast majority of doctors assessed treat-ment with oxycodone/naloxone PR as "much better or better" than previous medication.
Conclusions: Oxycodone/naloxone PR proved effective and well tolerable in patients with severe and very severe cancer pain. The strong analgesic efficacy combined with improved bowel function markedly increases quality of life.

PE 2.S300

The management of pain in palliative care patients with a history of substance misuse: The development of regional guidelines

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Aims: The management of pain in palliative care patients with a history of substance misuse can be challenging. Patients are likely to have a low pain threshold and can feel ill at ease in unfamiliar healthcare settings. In addition health care professionals are often reluctant to prescribe the appropriate opioid dose due to fears of exacerbating the addiction or contributing to a drug overdose. The resulting sub-optimal care leads to poor symptom control for this group of vulnerable patients at the end of life.
Methods: Following a review of the current literature we met with the local substance misuse service. A questionnaire was sent to all senior palliative care physicians in the region to establish both their current links with local drug misuse services and their approach to managing palliative care patients with a history of substance misuse.
Results: Until recently there has been no common consensus on how to manage this group of patients. Our proposed guidelines focus on the need for a co-ordinated approach from all care providers, with particular focus on the involvement of the patients key worker and the nomination of a named prescriber. Existing opioid replacement therapy with methadone or buprenorphine should be maintained to avoid opioid withdrawal. It should be clear to the patient and other healthcare professionals what drug s are being used for pain. It may be necessary to establish ground rules with the patient around the prescribing and dispensing of their medication.
Conclusion: Symptom control can be optimised in this challenging group of patients. Close working between palliative care and substance misuse teams ensures that a clear plan of care can be formulated with the patient and all the health care professionals involved in their care.

PE 2.S301

The impact of pain on behavioural disturbances in patients with moderate and severe dementia

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Aim: In nursing homes (NHs), 80% of the patients have dementia, and considerable proportion exhibit behavioural and psychiatric disturbances (BPSD). The prevalence of BPSD in the NH ranges between 60%-80% and includes physical combativeness, verbal aggression, socially disruptive behaviour, depression, and wandering. The aetiology of BPSD is poorly understood, but it is considered that it is multifactorial, including brain changes, genetics, diseases and pain. Advancing age is associated with high prevalence of pain often with pain duration of 3 months or more, and there are indications that pain is more frequent in those with dementia. Since older persons with dementia have less communicative skills, pain may contribute to BPSD. Few studies have explored such relationship, but there is some preliminary support for this hypothesis. This is of key importance, since a relationship between pain and agitation will have therapeutic implications, implying that pain medication could improve BPSD in dementia.
Methods: A systematic review of the literature will focus on the frequency, assessment and impact of pain on BPSD in NH patients with dementia. Review from the literature will be undertaken by electronic databases: CINAHL, Bandolier, Cochraine Pain, Medline, EMBASE, IASP website (1992-2008). Explicit in/exclusion criteria will be outlines. Search terms will include dementia, pain, -assessment, -treatment, behavioral disturbances, agitation, neuropsychiatric symptoms. Reference lists of retrieved articles will be used to generate more papers and search terms. Two reviewers will extract data from included trials. Data will be pooled, and analysed using appropriate statistical methods. Analysis will be discussed regarding the impact of pain on BPSD, including patients treated with an antipsychotic, pain medication compared with placebo.
Conclusion: Current literature review will explore a potential relationship between pain and BPSD in patients with dementia in NHs.

PE 2.S302

Breakthrough pain: The "best unknown pain syndrome"

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Breakthrough pain (BP) is a syndrome defined by:
Rapid onset of acute pain, lasting from seconds to hours (range 30 minutes), known factors as movements, cough, miction, respiration, deglutition or unknown: like neuropathic pain, co-existing chronic pain syndrome and/or an adequate chronic treatment. The underlying disease is often cancer.
Differential diagnosis relies on clinical signs and symptoms. Treatment is usually disappointing.
We conducted a one year survey in our supportive care department in order to analyze BP.
42 admissions on 209 (35 patients) were related to BP.
Some patients have been hospitalized twice or more.
Median duration of hospitalization was 7 days.
All patients had progressive cancer disease with metastatic lesions.
All had opioids (i.e morphine, fentanyl, hydromorphone) and co-analgesics (antidepressants,

anti epileptics or steroids).
BP episodes occurred more than four times a day.
Treatment options were methadone (oral or IV) or opioid rotation, gabapentine or pregabaline and or ketamine IV. We used oral transmucosal fentanyl citrate (OTFC) in four cases (compassionate use).
All patients improved but side effects were of concern especially with high doses of opioids (constipation, somnolence, myoclonus).
Beside the treatment, the estimated cost of hospitalization for one patient with BP was 3 758¤ (for 7 days). This is of importance if we note that patients receiving OTFC stayed less than 3 days at hospital.
BP remains a challenge in supportive and palliative care. Diagnosis requires expertise and the cost of treatment has to be taken into account. Avoid long stay at hospital is a priority. All data will be presented in details.

PE 2.S303

Should patients with a history of drug dependence ever be prescribed short acting opioids? A case report

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A 30 year old male with metastatic gastrointestinal stromal tumour was on fentanyl patches for abdominal pain and had been started on fentanyl lozenges as part of a clinical trial of 1200mcg qds, for breakthrough pain. The lozenges gave him a high feeling allowing him to interact better socially with friends. He had been diagnosed by a psychiatrist with social anxiety disorder, depression and drug dependence which he would not accept. He had a past history of recreational drug use. He was admitted complaining the fentanyl patches only lasted 20 hours and he felt he was withdrawing with all over body pain, joint pains, extreme agitation and sweats. He was on fentanyl patches 200mcg every 48 hours, fentanyl lozenges 200mcg 6 per day and diazepam 10-15mg daily. His patches were removed, lozenges stopped and he was converted to methadone 20mg bd and diazepam 5mg nocte. The first night he had severe withdrawal effects, screaming and threatening to jump out the window. He was seen by a psychiatrist and admitted to taking up to 80mg diazepam daily. He was put on a reducing regime of diazepam and methadone increased to 30mg bd. He was discharged a week later with ongoing pain and seen on a weekly basis to be given a script by a single prescriber. His pain settled and he was able to walk several miles and play golf. After several weeks he was able to admit he had been dependant and felt he had now come out of the fentanyl fog. This case highlights that prescribing of opioids in cancer patients can exacerbate pre-existing drug dependence. The use of quicker onset opioids such as fentanyl lozenges and the new effervescent fentanyl tablet and nasal spray is likely to make this an increasingly recognised problem as patients will enjoy getting the quick high sensation. Patients with a history of recreational drug use, other dependence or a dependent type personality may be more susceptible and therefore a thorough history and screening should be undertaken. The question remains!

PE 2.S304

Intranasal fentanyl spray (INFS) for relief of breakthrough pain in patients with cancer: Evidence of dose response

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Aim: To examine the analgesic effect and tolerability of three doses of intranasal fentanyl spray (INFS) of 50, 100, 200 µg, for relief of breakthrough pain (BTP) in patients with cancer.
Methods: This was a randomised, double-blind, placebo-controlled, crossover, multicentre trial involving adult in-/outpatients with cancer, receiving stable, chronic opioid who experienced BTP. The BTP episode was treated with INFS/placebo, with one dose in one nostril, from a pack containing eight numbered sprays randomly and evenly providing strengths of 0 (placebo), 50, 100 and 200 µg fentanyl per dose, for a total of eight episodes. Pain intensity (PI) was recorded on an 11-point NRS up to 60 min after first dose, and general impression (GI) at 60 min using a 5 point VRS. The primary efficacy measurement was the PI difference at 10 min (PID10) after the first dose (PI at 10 min minus PI immediately before treatment (PI0)). Sum of PID values up to 60 min (SPID60) and use of rescue medication were also recorded, as were adverse events (AEs).
Results: Among 159 patients randomised, 152 composed the ITT analysis set (89.5%) and 138 (90.8%) completed the double blind treatment phase. The LS mean vs placebo PID10 scores for INFS were 0.41, 0.81, 1.24, for 50, 100, 200 µg, ($p = 0.001$, $p < 0.001$, $p < 0.001$ respectively) with response rates of 29.05%, 41.55%, 49.66% for the respective three INFS doses vs 22.07% for placebo. Similarly, mean GI scores and SPID60 scores were significantly higher compared with placebo for all INFS dose groups ($p < 0.001$ throughout for both measurements). Use of rescue medication was incrementally lower after INFS use: 33.0%, 25.0%, 16.7% vs 43.3% for placebo. Incidence of AEs was low and all doses were well tolerated.
Conclusion: INFS at doses of 50,100,200 µg demonstrated fast onset of pain relief as early as 10 minutes after dosing, in the treatment of BTP in patients with cancer. All doses of INFS were well tolerated.

PE 2.S305

Pharmacokinetics of intranasal fentanyl spray (INFS) in patients with cancer and breakthrough pain

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Aim: This Phase Ib study investigated the pharmacokinetics, tolerability and safety of intranasal fentanyl spray (INFS) in patients with cancer and breakthrough pain (BTP).
Methods: This was a randomised, open-label, two-period, cross over trial involving adult patients with cancer who received opioid treatment for chronic background pain and experienced BTP. Patients were randomly assigned to receive one of six INFS dose sequences: 50-100 µg; 100-50 µg, 50-200 µg, 200-50 µg, 100-200 µg, and 200-100 µg. INFS was administered as a single dose in one nostril. Venous blood samples were collected at 0, 2, 4, 6, 9, 12, 15, 20, 25, 40, 60, 90, 120, 180 and 300 minutes after INFS administration. Blood pressure, peripheral oxygen saturation, and respiratory rate were assessed five times during the two treatment periods.
Results: Among the 19 patients randomised and who completed the trial, median age was 60.0 years (range 39.0 - 68.0). Mean fentanyl plasma concentrations increased in a dose-dependent manner, peaking for all INFS doses 9-15 minutes after INFS administration. Median Tmax values were 15, 12, and 15 minutes for the 50, 100, and 200 µg doses of INFS respectively. Mean values (SD) for Cmax were 0.351 (±0.226), 0. 595 (±0.400) and 1.195 (±0.700) ng/mL for the three doses respectively. Over the entire 50-200 µg range Cmax appeared to increase slightly less than proportionally to INFS dose. Six patients (31.6%) experienced adverse events (AEs) during a treatment period, the majority being mild. Nausea and hypoxia (in two patients each) were the only AEs reported for more than one patient.
Conclusion: INFS at doses of 50, 100, and 200 µg showed a short venous Tmax and was well tolerated in patients with cancer. The pharmacokinetic profile of INFS strongly supports its use as a treatment for breakthrough pain.

PE 2.S306

Advantages of oral opiates in complex cures of patients with severe funcitonal dependence. A nursing view

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Introduction: Patients admitted in a Hospital at Home Unit (HHU) can need nurse techniques for treatment of diverse ulcers and wounds than lead to the use of intense analgesia during cures, including opiates derivates. Oxycodone hydrochloride and fentanyl are two pure opiate agonists, with very high oral bioavailability, a plasmatic mean life of 2-4 hours, and a fast beginning of analgesic effects.
Objectives: To study the analgesic efficacy of oxycodone and fentanyl in complex cures of ulcers and wounds of a group of patients with severely limited functional autonomy who require cures at home. To analyze the correct administration of opiates by caregivers and their possible adverse effects.
Methods: 23 patients diagnosed of painful ulcers or wounds, with bad response to non-steroidal anti-inflammatory (NSAI), were treated with doses of oral oxycodone (2-4 ml), or 400 µg of oral fentanyl. During every day of treatment, the nurse called at caregiver one hour before visit at home, for the correct administration of drug. Previously we trained caregivers about opiates. We measured analgesic intensity with the Visual Analog Scale (VAS) during the cure without opiates (VAS-W), and during the cure with opiates (VAS-O). We registered also the incidence and intensity of its side effects, and the incidences in administration of drugs by caregivers.
Results: 9 men, 14 women, mean age: 74 years (range 56-98). Mean treatment duration 29 days (range 7-90). VAS-W: Mean 8.7 (range 7-10). VAS-O: Mean 2.5, range 0-5. Side effects: We have not detected any relevant side effect associated to punctual doses of oxycodone. There was not a single wrong administration given by caregivers.
Conclusions: Punctual treatment with oral oxycodone or fentanyl is a good alternative to conventional analgesia for painful cures of complex vascular ulcers at home. It's really effective and easy to manage by caregivers, and it's safe for patients.

PE 2.S307

Treatment of moderate to severe pain of opioid-naïv patients with the combination of Prolonged-Release (PR) oxycodone and PR naloxone

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Research aims: Analysis of the therapy of moderate to severe pain of opioid- naïv patients with a new combination of PR oxycodone/PR naloxone.
Study design and methods: During a 4 week observation phase of a multicentric non-interventional study data was collected at 4 assessment visits (of which the 2nd was optional). Pain intensity was measured with NRS 0-10: no pain- worst imaginable pain). The bowel function index (BFI), a patient-reported 3-item index (NAS 0-100), was used to measure the bowel function. Additional gastrointestinal symptoms were assessed with a 5 point scale and quality of life using the overall score (0 - 70 = no limitation - worst limitation) for the 7 usual parameters. At trial completion, doctors and patients assessed efficacy and tolerability, additionally they assessed the tolerability of the therapy compared with the previous therapy.
Results: In total 7836 patients with moderate to severe pain were included in this study. 5849 were previously treated with a WHO step II or step III opioid. 1963 patients were opioid- naïv before entering the study. The results of the subgroup analysis of the opioid- naïv patients are presented here. Mean pain intensity of these patients decreased after changing to PR oxycodone/naloxone within the 4 weeks by 2.9 points. The BFI decreased from ∅ 23.3±27.2 to ∅ 12.0±16.8. The percentage of patients with symptoms like nausea, vomiting and dizziness decreased strongly within 4 weeks. Quality of life increased by more than 50%. In the final assessment, the vast majority of doctors and patients assessed efficacy and tolerance as "very good" and "good".
Conclusions: Patients who have to be treated with an opioid for the first time benefit from the strong efficacy and the superior tolerability when treatment is started with PR oxycodone/naloxone. Additionally they sense a strongly improved quality of life.
Acknowledgments: Supported by grants from Mundipharma GmbH Germany.

PE 2.S308

Predictive validity of an abbreviated form of the Edmonton Classification System for Cancer Pain (A-ECS-CP) in advanced cancer

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The aim of the present study is to evaluate the predictive performance of an abbreviated form of the Edmonton Classification System for Cancer Pain , the A-ECS-CP, in a population of advanced cancer patients. Data analyzed come from a multicentre observational cancer pain national study, involving 123 centres on a sample of advanced cancer patients in which the A-ECS-CP was applied at baseline evaluation. The A-ECS-CP is defined by two components only: the presence of the neuropathic pain and of incident pain. It assumes values from 0 to 2 indicating the number of pain characteristics present. For each patient average pain intensity of the previous week was gathered at baseline, and weekly for the 4 following weeks. On each occasion pain was defined as controlled if the average pain intensity of the previous week was ≤3 on a 0-10 NRS. Predictive validity will be evaluated as the capability of the a-ECS-CP to discriminate patients in terms of two outcome measures: time needed to reach the first pain control and proportion of follow-up period with pain controlled. Of 1801 consecutive patients enrolled in the study, 1696 (94%) had complete data on variables examined and were then involved in this analysis. The A-ECS-CP classifies patients into three groups: Group_0 (neither neuropathic nor incident pain) 667 patients (39%), Group_1 (neuropathic or incident pain) 729 patients (43%) and Group_2 (both neuropathic and incident pain) 300 patients (18%). These groups reach their first pain control at different median times: 6, 8 and 14 days respectively for Group_0, Group_1, Group_2 and have different average percentage of follow-up period with pain controlled: respectively 63%, 55% and 44% (Kruskal-Wallis test: p=0.0001). The predictive validity of the index shown by our results, indicates that a simple and easy tool such as the A-ECS-CP may be a useful instrument to be applied in daily clinical practice.

PE 2.S309

How do nurses assess and manage breakthrough pain in specialist palliative care inpatient units? A multi-centre study

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Background: Breakthrough pain (BTP) is a common and debilitating problem. Increasing numbers of drugs are available to treat this distressing symptom. The nursing assessment is a vital part of symptom management for inpatients.
Aims:
• To gain understanding into how nurses working on inpatient specialist palliative care units assess and manage BTP.
• To help overcome any barriers limiting the effective management of BTP.
• To identify any specific training needs.
Methods: Semi-structured interviews were conducted with fifteen trained nurses (Bands 5 and 6), working in 5 different inpatient specialist palliative care units. These nurses had all worked in their unit for more than 6 months and were chosen at random, to enter the study. Thematic analysis was used to look for emergent themes from the interviews.
Results: The most significant themes were:
• BTP was not seen as a separate entity.
• Holistic assessment was deemed very important and can hinder specific assessment of the physical components of BTP.
• Nurses viewed themselves as the patient's advocate.
• Nurses' choices around which specific drug to use for BTP depended on a number of physical aspects of care.
• Training was not mentioned by any nurse.
• Theoretical work on BTP needs to be translated into a nurse's day to day practice.
• Nurses report that being able to conceptualize BTP to a patient story is helpful.
• Doctors and nurses use different language for describing pain.
Conclusions: This study provides original data that is highly relevant to specialist palliative care. As advances are made with new treatment options for BTP, the multidisciplinary team must be included in training and policy working groups. The language used and teaching methods may need to be adapted for different members of the team. This is essential in order to improve the management of BTP.
Funding: Educational grant from Cephalon UK Ltd.

PE 2.S310

Percutaneous cordotomy for advanced cancer pain - Is it effective?

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Background: Severe pain from mesothelioma and other unilateral cancerous pathologies can be difficult to control with conventional pain management techniques. Percutaneous cordotomy has been thought to be beneficial for some of these patients, however evidence for its effectiveness remains limited in this setting.
Aim: To assess the effectiveness of percutaneous cordotomy in unilateral cancer pain.
Methods: Data is being collected prospectively for a period of one year, from patients seen in the joint pain clinic between a District General Hospital Palliative Care Team and a pain management team from a neurological tertiary referral centre. Data analysed includes type of pain, pain scores, medication side effects, tolerability of the procedure and survival.
Results: (figures show data collected to date - further results to be included and will be presented graphically and in full colour).
A total of (7) patients underwent percutaneous cordotomy. 71% presented with severe, unilateral chest pain from mesothelioma. All patients had been tried on strong opioids, and 70% admitted to suffering bothersome side effects due to their medication. The average pain score prior to procedure averaged 7.5/10, and overall mean pain relief score following the procedure was 8/10.
On the whole the procedure was well tolerated, with 86% experiencing a mild, temporary headache, and one patient having a transient episode of leg weakness. Overall, 86% patients felt the procedure had been worthwhile. The average survival of patients was 53 days, highlighting the late timing of referral for many patients.
Conclusion: Percutaneous cordotomy is effective in the management of severe unilateral cancer pain in selected patients. There is a high acceptance of the procedure from patients, and side effects are generally transient and well-tolerated. Awareness amongst clinicians should be raised to facilitate earlier referrals of suitable patients for this procedure.

PE 2.S311

Circadian variation in opioid consumption in inpatients with chronic cancer pain - A PCA based study

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Aim: The circadian variation in opioid requirement is still under discussion.
Methods: Retrospective data review over a 10 year period (1997-2006) of all inpatients treated with intravenous strong opioids via a PCA device at the University Hospital Erlangen.
Results: Of the 3631 inpatients provided with a PCA system during the study period, 214 were treated due to chronic cancer pain (not postoperative pain), 141 patients met the inclusion criteria and were eligible for analysis. Their median age was 59 years (range16-83). Mainly they suffered from advanced gastrointestinal tumours. 119 patients (84%) received morphine, 22 (16%) piritramide. The mean cumulative 10 day-dose per patient was 671 mg (median 470 mg; range 10 to 2170 mg per patient and 10 day treatment period). In the whole 10 day study period patients administered themselves less opioids by bolus option during the night (10:01 p.m. to 06:00 a.m.; 69 mg; 25%) than during the other two eight hour periods (06:01 a.m. to 02:00 p.m. and 02:01 p.m. to 10:00 p.m.; 91 mg (33 %) and 116 (42%), respectively). In 8 out of 10 days there was a significant diurnal variation in opioid requests by bolus option with significant lower requirement during the night ($p < 0.05$; Friedman test). The median number of delivered/undelivered bolus requests during the night was 0-1/null, respectively. In the morning and during the afternoon period the median number of delivered/undelivered bolus requests was 1-4/0 and 0.5-3/0 respectively.
Conclusion: Opioid use in inpatients with cancer pain treated with intravenous PCA shows a circadian pattern with less opioid requirement during the night. It seems to meet individual opioid needs indicated by the huge interindividual variability in opioid consumption and the rare event of an undelivered bolus request during lock out time.

PE 2.S312

The efficacy, tolerability and onset of action of fentanyl pectin nasal spray (FPNS) with PecSys® in the treatment of breakthrough cancer pain (BTCP): A multicentre, placebo-controlled, double-blind, two-phase crossover study

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Aim: To assess efficacy and safety of a new nasal formulation of fentanyl (fentanyl pectin nasal spray [FPNS]) in the treatment of breakthrough cancer pain (BTCP).
Background: BTCP affects most cancer patients; oral rescue drugs provide a time course of analgesia that does not match the typical time course of BTCP. FPNS has kinetics that should provide a more rapid onset of pain relief.
Methods: Patients (N=114) experiencing 1-4 BTCP episodes/day while taking >60 mg/day of oral morphine (or equivalent) for cancer pain were entered into a randomised, placebo-controlled, double-blind (DB) study (Archimedes CP043). Those who completed an open-label titration phase (N=83) continued to a DB phase; 10 episodes of BTCP were treated with the effective dose (7) or placebo (3). Pain intensity (PI; 11-point numerical scale) and pain relief (PR; 5-point scale) were measured at 5, 10, 15, 30, 45 and 60 min post-dose. The primary endpoint was the summed pain intensity difference at 30 min (SPID30). Secondary endpoints included pain intensity difference (PID) from baseline, PI and PR. Safety was assessed by adverse events (AEs) and both objective and subjective nasal assessments.
Results: FPNS significantly improved mean SPID30 score compared with placebo (P<0.0001; modified intent-to-treat analysis N=73) and provided significant improvements in SPID from 10 min (P<0.01) to 60 min (P<0.0001). Significant differences in favour of FPNS were found in PI as early as 5 min (P<0.05). Similar changes were seen with PID, with a trend at 5 min (P=0.07) that was significant from 10 min onward (P<0.01). PR was also significant from 10 min (P<0.001) and at all time points to 60 min (P<0.001). Only 5.3% of patients withdrew from titration (1.2% in DB phase) due to AEs; no significant nasal effects were reported.
Conclusion: FPNS was efficacious, safe and provided relatively rapid onset of analgesia in BTCP.
Sponsored by Archimedes Development Ltd.

PE 2.S313

Fentanyl pectin nasal spray (FPNS) with PecSys® provides most favourable pharmacokinetic/tolerability profile compared with nasal chitosan-based fentanyl and oral transmucosal fentanyl citrate (OTFC)

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Aim: To select an optimal nasal formulation by comparing the pharmacokinetic/tolerability profiles of three fentanyl nasal spray formulations with oral transmucosal fentanyl citrate (OTFC).
Background: The nasal route offers the ability to enhance fentanyl delivery and better match the time course of breakthrough pain compared with oral delivery. However, conventional nasal fentanyl solutions are associated with variable and supratherapeutic maximum plasma concentrations (Cmax). To optimise and modify absorption and reduce Cmax, three nasal spray formulations have been developed: fentanyl pectin (FPNS), fentanyl chitosan nasal (FChNS) and fentanyl in chitosan-poloxamer 188 (FChPNS).
Methods: This early Phase I, open-label, crossover study (Archimedes CP037) was conducted in 18 healthy adult volunteers treated with naltrexone hydrochloride to block centrally mediated opioid effects. Subjects were dosed on four occasions, separated by a ≥3-day washout period, with the three nasal sprays (each containing fentanyl citrate 100µg in 100µL) and OTFC 200µg according to a randomised sequence. Fentanyl venous plasma concentrations were measured before and up to 24 hours post-dose. Tolerability was assessed by clinical nasal assessments and a nasal reactogenicity questionnaire.
Results: Mean AUCs∞ for all nasal sprays were significantly higher (P<0.05) than for OTFC; accordingly, Frel compared with OTFC was significantly greater for all nasal sprays (FPNS 132%, FChNS 154%, FChPNS 122%). Median Tmax (FPNS 19.8 min, FChNS 10.2 min, FChPNS 15.6 min) was significantly (P<0.001) reduced (OTFC 90 min) and mean Cmax significantly increased with all nasal sprays vs OTFC. FPNS had the lowest nasal reactogenicity symptom incidence.
Conclusions: Fentanyl from all nasal spray formulations showed significantly increased absorption and reduced times to peak plasma values compared with OTFC. FPNS exhibited the most favourable tolerability profile.
Sponsored by Archimedes Development Ltd.

PE 2.S314

Management of neuropathic pain in cancer patients - Retrospective study

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Aims: To study the management of neuropathic pain in cancer patients.
Methods: Retrospective study with collection of clinical records of cancer patients with neuropathic pain having their first evaluation at the Pain Clinic in 2007. Neuropathic pain was considered on clinical aspects. Pain was classified into five levels in a qualitative scale: no pain; weak; moderate; severe; maximum. 95 patients were included but only 85 have the required data: 1 refused treatment and 9 died before follow-up evaluation.
Results: From the 85 patients, 60% were male and 40% female. Mean age was 61 (25 - 88 years).
The most frequent tumors were colo-rectal (18%), head and neck (15%), lung (12%) and multiple myeloma (12%).
59% of the patients have metastasis on the first evaluation.
Before treatment, the degree of pain was: weak (2%), moderate (12%), severe (68%) and maximum (18%).
After treatment, the degree of pain was: no pain (52%), weak (21%), moderate (25%) and severe (2%).
The time to achieve the better control of pain was less then 90 days in 69% of the patients.
In 69% of the patients the pain control was achieved with 4 or less drugs.
Conclusions: Although neuropathic pain is hard to manage, in our population we could get good results: 73% of the patients had weak pain or no pain after treatment and 69% of the patients achieved control of the pain in less then 3 months with 4 or less drugs.

PE 2.S315

By the ladder or the knife? Are interventional pain techniques essential for the pain of mesothelioma?

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Background: Merseyside and Cheshire Lung Clinical Network Group guidelines suggest that patients with mesothelioma should be referred early for interventional pain techniques rather than referring those for whom traditional analgesic titration, using the WHO ladder and appropriate adjuvants, have been unsuccessful. In our local area those with difficult pain symptoms are referred to the Specialist Palliative Care Services (SPCS) who would then generally refer on to the Pain Relief Anaesthetic service for such intervention. The aim was to see whether this suggested pathway would have been helpful for the patients we had seen.
Method: A retrospective review of all referrals to the SPCS over a five year period established the number of patients with mesothelioma which had been referred. An audit of the clinical records of those with mesothelioma established how many had pain which was difficult to control or where interventional pain techniques were considered due to failure of titration of opioids and adjuvants in the usual manner.
Results: This poster displays the results of the audit compared with the current recommendations that all patients with mesothelioma should be referred early for consideration of interventional pain techniques and makes suggestions as to the suitability of this recommendation.

PE 2.S316

The availability of pain controlling drugs in HIV care facilities in Kenya: A multi-methods study

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Aims: Pain is prevalent throughout the HIV trajectory. This study aimed to determine the availability of pain controlling drugs in HIV care facilities in Kenya.
Design and methods: This cross-sectional study used multiple methods to determine drug availability. 10% of 600 HIV care facilities were randomly sampled. Self-report surveys were conducted on site, and senior staff reported on availability of: strong opioids, weak opioids, non-opioids. Subsequently, pharmacy review was conducted and the current levels, stock-outs in the previous 6 months, and expiration of drugs were verified by the researchers who viewed stocks.
Results: Of the 60 sites, morphine was reported as available in 3 (0.05%) sites, and was found to be present within expiration date in 1 (0.02%). No stock-outs in the previous 6 months were reported. Weak opioids were reported as available in 16 (27%) sites, and were found to be present within expiration date in 23 (38%). Stock-outs in the previous 6 months were reported by 11 sites (48% of those who stocked the drug). Non-opioids were reported as available in 50 (83%) sites, and were found to be present within expiration date in 46 (77%). Stock-outs in the previous 6 months were reported by 27 sites (54% of those who stocked the drug).
Conclusion: It is of significant concern that opioids were identified within so few HIV care facilities, particularly when specialist palliative referral centres are so rare. Also, injectable morphine was the only formulation available in Kenya, therefore the WHO pain ladder could not be adhered to, and home maintenance of pain relief would be unfeasible. Weak opioids were more commonly available, but still in only fewer than half the facilities. Even non-opioids were unavailable for some, and frequently there were stock-outs. The availability of pain controlling drugs, which are cheap and effective, must be an urgent area of clinical, funding and policy attention in order to respond appropriately and humanely to the HIV epidemic in Africa.

PE 2.S317

The role of cordotomy in the management of mesothelioma-related pain in the United Kingdom (The INPIC pilot study) (invasive procedures in cancer pain)

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We report on an NCRI-funded UK-wide pilot study on the use of cordotomy in cancer pain and the potential of using the proposed research methodology to study wider topics in palliative care.
Background: There are around 1800 new cases of mesothelioma annually in the UK and the incidence is rising. Symptom control is central to the management of patients with mesothelioma as the disease is often associated with difficult pain syndromes resistant to pharmacological approaches. The National Mesothelioma Framework (UK 2007) indicated that patients should have access to cordotomy as a palliative intervention.
There is great inequity in service provision offering cordotomy in the UK and the level of evidence to support provision is poor. The procedure may yield significant analgesic benefit, but there is an unquantified risk of associated morbidity.
Aims, design and funding: We received a NCRI Lung Cancer SuPaC Research Award to
- do a systematic literature review examining the evidence-base on the use of cordotomy
- use Consensus methodology (Delphi and Nominal Group techniques) to clarify the role of cordotomy, provide a benchmark for the availability and produce national guidelines for use of this procedure
- in partnership with Industry to set up a National Register (UK) for Cordotomy.
We anticipate that the study will produce a more reasoned and robust governance framework to guide clinicians and commissioners on the use of cordotomy in mesothelioma-related pain management. The benefit will be a more equitable and effective service provision for patients. The registry and subsequent registry reports will inform clinicians more fully on the outcomes of the intervention, and hence aid the users in making informed choices.
If the methodology is successful, we plan to apply it to other interventional procedures in the cancer pain management. The methodology also lends itself to study wider palliative care interventions on a national, and even international basis.

PE 2.S318

Physical and spiritual pain assessment and its control adequateness among the end-of-life patients receiving home-based palliative care in Georgia

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Background: As there are over 43,000 deaths per year in Georgia, over 25,000 persons per year (60%) need palliative care. Palliative care and related pain relief are one of the major unaddressed public health problems in Georgia. Spiritual pain is also very common suffering of end-of-life patients requires adequate assessment and evaluation.
Aim of study: To evaluate the adequateness of physical and spiritual pain assessment and control among the home-based palliative care suitable patients in Georgia and analyze the ways of its improvement.
Methods: Physical and spiritual pain assessment and their control adequateness were evaluated by using of especially worked out questionnaires. 250 questionnaires filled by patients (and their family members) curried by mobile team of Palliative Care Association "Humanists' Union" (AHU) underwent to analysis. Complete evaluation and relieve of physical and spiritual pain was considered as an indicator for the successful control. The method of inferential statistics was used.
Results: During the 2006-2008 by the mobile team of AHU have been provided care of 236 end-of life patients in Tbilisi. Physical and spiritual pain were revealed as the one of most unresolved symptom for control (p<0.0001). Its adequate assessment and adequate management was insufficient in 108 cases (43.9%). Spiritual pain was assessed in one third of above

mentioned patients, which was the result of an aggregate of events and choices, each dynamically related to the other.
Conclusion: For medical professionals it is very important to clarify, assess and control adequately physical and spiritual pain.
The problems of Physical and Spiritual Pain management of end-of life patients in Georgia should be caused by lacking of:
1) legislative bases,
2) list and forms of opioids and their availability,
3) information shearing and
4) knowledge and experience of health care professionals (to assess, evaluate and have adequate control).

PE 2.S319

Continuous intravenous lidocaine mitigates chronic back pains caused by bed sores - A case report

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Background: A intravenous or subcutaneous infusion of lidocaine has been reported to alleviate opioid-refractory pain.
Case: A 56 years old male was admitted to our hospital for the purpose of pain control, with colon cancer, accompanied with leg paralysis caused by multiple lung metastases/lumbar spine metastases. At the time of the admission, low back pain and severe numbness of lower extremities were accompanied, caused by lumbar spine metastases. After the admission, NSAIDs, continuous subcutaneous injection of morphine and ketamine, and steroid, antidepressant were started to be administered, and the pain was extinct. On Day 28, however, as the metastatic lesion of lumbar spine increased gradually, paralysis of the lower extremities progressed, making self-orientation of the body difficult, and accompanied with it, a pain of the part where the body touched the bed appeared, making sleeping during the night difficult. The pain remained despite of use of the body-pressure-spreading bed, careful care of the skin in the contact area, and treatment of changing body position, with the Numerical Rating Scale(NRS) of 6/10. Although increasing the dose of morphine or ketamine was performed, strong sleepiness appeared, forcing to go back to the original dose. Because of the situation, continuous intravenous infusion of lidocaine was considered and an administration of 100mg/day was started. However, as low blood pressure was observed in 2-3 hours after the administration, it was reduced to 50mg/day immediately. On Day 34, Since then, gradual improvement of the pain was observed with the NRS improved to 2/10 next day and with having a good sleep as well. Afterwards, he achieved effective pain controlled until he died on Day 46. This condition was able to be maintained until the patient passed away on Day 46.[Conclusion] This case suggest that continuous intravenous infusion of lidocaine seem to be effective and safe treatment for bedsores.

PE 2.S320

Validation of the Arabic version of the M. D. Anderson Symptom Inventory (MDASI-A) in the moroccan cancer patients

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The purpose of this study was to demonstrate the validity and reliability of the Arabic version of the M. D. Anderson Symptom Inventory (MDASI-A). This instrument is an Arabic translation of the MDASI, also known as the MDASI-Core, a multisymptom assessment tool developed by Cleeland et al., in 2000, validated in cancer patients. A focus group of healthcare professionals and native Arab translators who were fluent in English used a forward-backward method to develop this Arabic version. Results of the psychometric validation are reported, as well as the prevalence and severity of symptoms in a sample of patients with advanced cancer in Morocco.
The study was conducted at the Pain Treatment Center of the Institute of Oncology in Rabat, Morocco, in collaboration with researchers at The University of Texas M. D. Anderson Cancer Center in Houston, Texas. A total of 165 patients presenting disease-related and treatment-related pain and other general symptoms participated in the study.
To assess the reliability of the MDASI-A, separate coefficients alpha were calculated for all items in the instrument, for the symptom items, and for the interference items (0.85, 0.78, and 0.79, respectively). Factor analysis with oblimin rotation identified a two-factor solution that is interpretable and that fits Harman's test for model fit. Subscale validity was examined using known group, based on the Eastern Cooperative Oncology Group (ECOG) Performance Status.
This Arabic version of the MDASI is a valid and reliable patient-reported outcome instrument that can be used among Arabic speaking cancer patients in Morocco. It could be routinely used for assessing multiple symptoms in cancer patients for a better oncology care.

PE 2.S321

Pain at third level controlled by rehabilitation interventions for patients with advanced cancer in palliative care unit

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Research aim: It is important for dignity of human-being including advanced or far advanced cancer patient to move independently. Though it is easier to control at rest pain, but it is more difficult to move physically for activities of daily living. Therefore we studied more controllable, comfortable or easy way of moving physically for cancer patient under third level of pain control in palliative care unit.
Study design and method: We selected one hundred eighty four cancer patients in palliative care unit in our institute from April 2003 to March 2008. Most patients were already under rest pain control, but they had strong request to success physical activities for their life with no pain or at least mild light pain. We used new approach of rehabilitation interventions under new theory which consists of three principles, such as slow movement, small step and using instruments for breaking up their body weight.
Results: Most of the patients could move by themselves with no pain or much less pain. In other words, they had no need of rescue medication for activities of daily living. Then they could stand up, walk alone or sitting down in their right places with pleasure because they had no pain or much less pain with any movements. As increasing movement level, it was parallel to improve quality of life level as well.
Conclusion: It was useful and helpful to adapt our approach for advanced cancer patient under rest pain control. It's not only for the patients to move with no pain but also for carers or staffs to prevent severe back pain at clinical settings. We were very happy to spend more comfortable or calm life with patients in palliative care unit.

PE 2.S322

Painful dilemma: Managing cancer pain in patients with drug addiction

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Background: Effective pain management in cancer patients with a history of substance abuse can be complex and highly challenging.
Aim: Review management of pain in cancer patients with a history of drug addiction referred in the last two years to the hospital specialist palliative care team (HSPCT) with a view to producing local guidelines.
Method: Retrospective case note review of cancer patients with a history of drug addiction referred to our team for pain management. The following data was extracted and collated: age, gender, diagnosis, type, site and intensity of pain, drug addiction history, details of maintenance therapy used for treating addiction, cancer treatment and pain management.
Results: 5 cancer patients with a history of drug addiction were referred to HSPCT. Age range was 28-58 years. All except one patient were ex-abusers. Four patients were on methadone; the dose varying from 30 mg-160mg per day and one patient was on 10 mg sublingual Buprenorphine as part of maintenance therapy for addiction. All patients had a mixture of nociceptive and neuropathic pain. Maintenance therapy for addiction was continued in all patients and additional treatment including opioids was prescribed to manage pain. We used a different opioid (fentanyl in four cases and oramorph in one) and co analgesics to provide analgesia enabling a clear distinction between the treatment of pain and the treatment of addiction. In all cases pain relief was achieved to patient's satisfaction. On going symptom control was continued either from outpatient clinic or in the hospice.
Conclusion: Adequate pain relief is possible in cancer patients with drug addiction. Methadone maintenance therapy is insufficient to provide adequate analgesia in this setting due to tolerance and additional treatment is necessary. Demands for increasing opioid doses need to be carefully assessed to discern untreated pain from potential drug seeking behaviour.

PE 2.S323

Assessment of analgesia and adverse effects of controlled release tramadol and dihydrocodeine in patients with cancer pain - Based on a modified ESAS

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Patients and methods: Open, prospective, randomised, cross-over study of 30 patients with nociceptive (visceral or somatic) cancer pain treated previously with non-opioids who received tramadol (15 patients) or dihydrocodeine (DHC) (15 patients) in controlled release tablets for 7 days, then drugs changed and administered for the next 7 days. Analgesia assessed by visual - analogue scale (VAS), adverse effects by modified ESAS (Edmonton Symptom Assessment System) with two additional scales for constipation and vomiting. Starting doses: tramadol 100 mg, DHC 60 mg both twice daily, titrated to satisfactory analgesia.
Results: In both groups decrease of pain intensity, better analgesia with DHC. After study completion 19 patients preferred DHC, 4 tramadol, 7 assessed both drugs equally effective. In DHC group patients reported in the first 7 days less dyspnoea, in the second week more constipation and trend towards more drowsiness, more activity in the first week and better sensation of well-being during both weeks, tramadol caused more nausea during both treatment weeks. No differences in appetite and vomiting observed, in first week patients treated with DHC were less anxious and less depressed. Serious adverse effects (respiratory depression, allergy for drugs) not observed.
Conclusions: Tramadol and DHC in controlled release tablets are effective analgesics in nociceptive cancer pain. No serious adverse effects observed, more constipation in DHC group indicates for prophylactic use of laxatives whereas more nausea in tramadol group is an indication for prophylactic antiemetic administration. Equianalgesic single doses of tramadol to DHC according to 10:6 ratio rendered satisfactory analgesia.

PE 2.S324

Optimizing the control of severe cancer pain: Add on therapy in stead of rotation of strong opioids

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Aim: To evaluate the effect of the combination of two opioids with a different MOR agonistic spectrum - Buprenorphine TTS (BUP TTS) and Fentanyl TTS (FEN TTS)- on pain scores in patients with severe cancer pain. Secondary: evaluation of the slope index of the opioïd dose curve.
Background: Most guidelines tell us to avoid the combination of strong opioids because of possible antagonism. Searching in pharmacological literature we found lot of arguments to combine opioids in order to get an additive effect.
Methods: Cancer patients were treated with FEN TTS. The dose was up titrated in proportion to the pain score. When the normal increase of dose did not give the expected decrease in pain score, we didn't rotate to an other opioid, but FEN TTS was diminished to the previous dose (=inclusion dose) and BUP TTS was added in an equivalent dose.
Results: 7 pts are already included an evaluated, a larger recruitment is ongoing. Starting doses FEN/BUP varied from 25µg/17.5µg to 200µg/105µg (av. 65/42.5). Doses FEN/BUP at study end varied from 25µg/17.5µg to 200µg/140µg (av.67.9/52.5). Observation period varied from 3 to 20 wk (av.10wk).
Pain scores could be kept under 3, by titrating the doses of FEN: 4.5% increase, but mainly by titrating the doses

of BUP: 24% doses increase.
Conclusion: Instead of the general believe that combination of strong opioids is to be avoided, we find no clinical evidence of antagonism, but we find an better pain control by combining two opioids with a different spectrum. There was a longer steady state without up titration of the doses. This opens new possibilities to treat severe cancer pain. More research is needed, so this abstract is a call for other investigators to set up a trial to optimize the combination and conversion rate.

PE 2.S325

Pamidronate is effective with analgesics in cancer pain treatment in patients with bone metastases - Two centers experience

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Aim of the study: To assess analgesia and tolerance of pamidronate in cancer patients with painful bone metastses.
Patients and methods: One hundred cancer patients with osteolytic bone lesions and bone pain of severe intensity (over 6 on 11-point numerical rating scale (NRS: 0 - no pain, 10 - the strongest pain). Patients treated with 2 h intravenous pamidronate infusion (Pamifos® and Aredia®, dose 30 - 90 mg in 500 ml 0.9% NaCl), every 3 - 4 weeks provided creatinine level under 2 mg%, calcium level normal/exceeded. All patients also treated with other analgesics (non-opioids, opioids), 30 radiotherapy, 10 hormone therapy, 4 chemotherapy. Analgesia assesssed after administration at least 2 pamidronate infusions (total 2 - 16 doses). Treatment continued till end of life or completed in case lack analgesia or significant patients deterioration.
Results: In 76 patients good analgesia (at least 2 points decrease in pain intensity) or less than 4 on NRS. In 12 patients partial effect (at least 1 point decrease of pain intensity) or 4 - 5 on NRS. In 12 patients no benefit, treatment terminated. Tolerance of treatment good, no severe adverse effects, the most common: temporary fever (20 patients), headache (8), intensifying bone pain (6). Symptoms did not cause pamidronate cessation, disappeared within 1 day without treatment. Local reactions 6 patients, 10 asymptomatic calcium level decrease, 6 creatinine level increase.
Conclusions: Pamidronate intravenous infusion every 3 - 4 weeks in dose 30 - 90 mg is effective in bone pain combined with analgesics and cancer therapy, treatment well tolerated with no serious adverse effects.

PE 2.S326

Use of Gabapentin in a girl with vincristine induced neuropathic pain

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Introduction: Neuromuscular toxicity of vincristine is well known, and the treatment neuropathic pain derived from its action can be a challenge especially in children.
Methods: We describe a case of severe neuropathic pain associated with intravenous Vincristine (VCR) administration in a 14-year old girl, weight 50kg with a diagnosis of T-cell Lymphoblastic Lymphoma, was on treatment according with protocol Euro-LB 02. Fifteen days after the 4th dose of VCR, she presented with mild weakness, allodinya, hyperalgesia on her left foot and ankle. On the following days, her pain worsened on both feet and ankles. She had difficulties extending her fingers, walking and dressing. The pain intensity was 8-9, according with the Visual Analog Scale. The neurological examination was normal, all deep tendon reflexes were present. There was a moderate loss of sensory modalities in her left foot. The patient had been physically active for all her life. A lumbar puncture revealed a normal pressure and normal cerebrospinal fluid. Magnetic resonance imaging (MRI) of the brain and the spine was normal. The treatment consisted of Gabapentin PO 100mg, three times a day, for five days; 200 mg three times a day for other five days, continuing with 300mg three times daily for one month. She also started physiotherapy and she received psychological support.
Result: After 15 days of therapy her pain decreased (VAS 2-3), and after one month we suspended Gabapentin.
Discussion: Recently Gabapentin has been proposed in the setting of the postoperative acute pain treatment,in adult. The neurophatic and symphatetic system can be involved often in children and adolescent, apparently without an objective reason. We consider physiotherapy and psychological intervention important keys of treatment, as part of the multidisciplinary approach to pain in children and adolescent.No source of funding was obtained for the study.

PE 2.S327

Opioid medication in hospice - Often too much?

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The aim of this prospective study was to assess the indication for opioids and quality of cancer pain control at the end of life in patients submitted to a hospice.
80 patients of two hospices were overviewed from the beginning of their stay in the hospice for the next two weeks; the monitoring was designed to investigate the morphine doses and indications in patients that were submitted to a hospice. In the following two weeks their opioid medication including rescue medication and pain intensity was monitored.
In more than 50% the Opioid medication has to be changed subsistentally during the next days in patients administered to a hospice. In some cases of overdosing side effects were remarkable and had not been recognized in the right way before.
There is much variation and even inappropriate indication for morphine use in end of life diseases.

PE 2.S328

Methadone in opioid rotation - Experience from Poland

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Aim of the study: To assess analgesia, adverse effects of methadone, calculation equianalgesic dose ratio of oral morphine to methadone.
Patients and methods: Twenty five opioid - tolerant patients with severe cancer neuropathic and bone pain (NRS > 5) not responding to morphine (16 patients), transdermal fentanyl (TF) (6), tramadol (2), and pethidine (1). Dose ratios of daily doses of oral morphine (ddom) to daily doses of oral methadone (ddomet): 4 : 1 (ddom to 100 mg), 6 : 1 (ddom 101 - 300 mg), 12 : 1 (ddom 301 - 1000 mg), 20 : 1 (ddom over 1000 mg). Previous opioids stopped in 21 patients, 4 treated with methadone and other opioids. Mean equivalent ddom before methadone switch 811 ± 466 mg. Methadone administered 3 times daily, 24 patients receive methadone orally, 1 rectally in suppositories. Breakthrough pain treated with methadone (half regular dose), morphine, fentanyl, metamizol, ketamine.
Results: Treatment time 37.3 ± 26.1 (range 3 - 95) days, daily dose range 9 - 400 mg, mean daily doses 46.1 ± 18.6 beginning, maximal 145.5 ± 102.1, 125.1 ± 101.3 mg end of treatment. Good analgesia (NRS < 4) 13 patients, partial (NRS 4 - 5) 9, unsatisfactory 3 (NRS > 5) stopped methadone. Adverse effects: drowsiness (7 patients), constipation (5), nausea and vomiting (2), one respiratory depression disappeared after naloxone administration and methadone cessation.
Conclusions: Results confirmed high analgesic efficacy, acceptable adverse event profile of methadone and effectiveness of dose calculation. Strict patients monitoring is mandatory especially for the first days after rotation to methadone.

PE 2.S329

Drug interactions in hospice patients- The advantage or a serious trap?

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Drugs interactions either pharmacodynamic and pharmacokinetic may be of great value in pain and other symptom management. However, unrecognized may produce a real danger eg. deep sedation and respiratory depression. The aim of this study was to evaluate the drugs used in patients with disseminated cancer to determine the combinations which potentially cause the highest risk of clinically significant interactions.
We analyzed data of 100 patients cared by home care team in Poznan. All the drugs with the focus on substrates and precipitants of main isoforms of CYP 450 (3A4, 2D6, 2C9, 2C19, 1A2) as well as the potential clinically important combinations were described.
In the group of patients (41 men and 59 women aged 29-93, mean 68) cared for a medium of 66 days as much as 1-9 (mean 4) substrates or inhibitors and inducers of main CYP isoforms were prescribed. Oral and subcutaneous morphine known to be metabolized primarily by glucuronidation was the most commonly used strong opioid. However, codeine and tramadol, which opioid activity is influenced by coadministration of eg. haloperidol or SSRI, was used in 59%, and fentanyl significantly influenced by multiple coadministrated drugs was second strong opioid used in the group. The other orded drugs were: midazolam and other CYP-metabolized benzodwuazepines (54% pts), omeprazol (52% pts) dexamethason (48% pts), haloperidol, promazine derivatives, anti-epileptics, TCA, SSRI, methadone, antibiotics. Additionally 38% of patients continued to take medication due to concurrent diseases (beta-blokers and amiodaron among others).
Managing symptoms in patients with advanced cancer employ drugs that may cause major interactions. While we need to make efforts to limit the number of drugs and avoid those which may produce undesired interactions we may additionally limit the risk by titration of a new drug and closely monitoring the patients. Pharmacokinetic surveys in the field of symptom control are awaited.

PE 2.S330

Quality of life in patients treated with controlled release dihydrocodeine and tramadol - Results of a prospective, randomised, cross-over study

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Aim of the study: Assessment of analgesic efficacy, side effects and quality of life (QL) during dihydrocodeine (DHC) controlled release tablets 60, 90, 120 mg and tramadol controlled release tablets 100, 150, 200 mg administration in patients with cancer pain.
Patients and methods: Thirty opioid - naive patients with nociceptive pain (VAS>40), randomised, cross - over, 7 days each analgesic without wash - out. QL assessed by EORTC QLQ C 30 three times: before treatment, after 7 days (before drug change) and after treatment completion. Results analyzed by ANOVA in case of significant differences in main effects further analysis by LSD test.
Results: In functional scales significant differences were observed in emotional functioning and in global QL (treatment time, interaction of drug and treatment time) - better results in DHC group. Similar results were near significance in physical functioning and role functioning (treatment time, p = 0.06) and in cognitive functioning (interaction of drug and treatment time, p = 0.052).
In symptom scales the most significant differences in favour of DHC in pain (treatment time, interaction of drug and treatment time, p<0.001), fatigue (treatment time, p<0.036), interaction of drug and treatment time, p<0.01), nausea and vomiting (interaction of drug and treatment time, p<0.001). The most significant difference in favour of tramadol in constipation (interaction of drug and treatment time, p<0.001). Slight differences in appetite (p<0.039) and financial problems (p<0.023) observed, no differences in dyspnoea.
Conclusions: DHC and tramadol in controlled release tablets are effective analgesics in nociceptive cancer pain, DHC provided better analgesia. QL results showed better analgesia and global QL in DHC group, more intense nausea and less constipation in tramadol group. Tolerance of treatment is good in both groups with no serious side effects like respiratory depression or allergy for the drug.

PE 2.S331

The Edmonton Classification System for Cancer Pain (ECS-CP): A prospective study in patients with advanced cancer who were referred to an inpatient hospice unit (IHU) and an acute tertiary hospital (ATH) setting

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Aim: To test in an Irish setting the hypothesis that underscored the development of the ECS-CP: more complex cancer pain syndromes require longer to achieve stable pain control, and require more intense treatment regimens.
Methods: This was an extension of an international multicentre study of the ECS-CP at two sites in Ireland, an IHU and an ATH. The ECS-CP was completed by palliative care clinical nurse specialists or physicians. Data were collected regarding anxiety and pain intensity, the number of daily opioid breakthrough (BT) doses and adjuvants used, and the parenteral morphine equivalent daily dose (MEDD) at initial encounter, and on the first day of stable pain control. Stable pain control was defined as <3 BTs per day or pain intensity of 3/10 or less. Time to stable pain control in days was calculated in relation to the ECS-CP and other variables, and then used as an event in a Kaplein-Meir survival analysis and a Cox regression model.
Results: Pain was present in 296/367(80.6%) of patients. Stable pain control occurred in 157/296 (67%). Neuropathic pain (NP) was identified in 50/296 (16%). In the Kaplan-Meir survival analysis, time to stable pain control was longer with NP($p<0.001$), incident pain($p=0.023$), psychological distress ($p=0.005$), age<60 ($p<0.001$), a history of drug or alcohol abuse ($p=0.02$), normal cognitive function ($p=0.01$), severe pain intensity ($p<0.001$) and an MEDD of >44mg on initial assessment ($p<0.001$). In the multivariate Cox regression model age and NPconsistently demonstrated an independent association with longer time to stable pain control, generating Hazard Ratios [95% confidence intervals] of 0.63 [0.45-0.88] and 0.42 [0.23-0.75], respectively. Neuropathic pain, incident pain, psychological distress, and younger age were associated with higher final MEDD.
Conclusion: These findings are consistent with those obtained by the Edmonton group and highlight the merits of comprehensive multidimensional pain assessment.

PE 2.S332

Intravenous ketamine for procedural pain in cancer patients

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During diagnosis and treatment, patients with cancer often undergo painful procedures, adding to the pain caused by the disease itself. Poorly managed procedural pain may prevent investigations and limit the ability to palliate or cure the cancer.
Ketamine is both an analgesic and at higher doses an anaesthetic. It can be used when patients develop opioid tolerance or hyperalgesia because it reverses the central N-methyl d-aspartate (NMDA) driven mechanisms. There is an extensive literature for using ketamine for refractory pain.
We describe 4 cases where IV ketamine was used by a palliative medicine team to good effect in patients who were unable to have critical investigations or treatment because of severe uncontrolled pain which was limiting their ability to lie flat or be moved. These patients were already on high doses of opioids and other analgesics and some cases demonstrated significant opioid toxicity. IV ketamine acts within minutes and can thus be carefully titrated to effect. Our practice is to give 2.5mg every 2 minutes until pain is controlled, without causing sedation. As ketamine has a half life of 1-3 hours, it will give good analgesic cover for most procedures. Psychotropic toxicity such as hallucinations can be prevented by pre-medicating the patient with a neuroleptic such as haloperidol. In cases of previous opioid tolerance we continue the ketamine by subcutaneous infusion for 5-7 days.
Palliative medicine physicians are increasingly involved with both cancer and non cancer patients at earlier stage of disease, using their skills in controlling severe pain and other symptoms. They could employ their skills to use ketamine similarly in acute pain situations. In experienced hands IV followed by SC ketamine can be safely given in an inpatient setting to patients with cancer related pain with rapid effect, enabling urgent investigations and potentially life prolonging or palliative treatments to be given.
Funded by local hospital.

PE 2.S333

Hyperalgesia and opioid switching in a patient with a neuropathic cancer pain

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Introduction: The underlying pathogenesis of neuropathic pain is very complex. Opioids are the gold therapy for the treatment of moderate to severe pain but accumulating evidence suggests that opioids also may cause opioid-induced hyperalgesia (increase in pain sensitivity with upregulation of pronociceptive pathways).
Case report: A 44 - year-old- man with a multirecidivant thoracic sarcoma to the right armpit, supraclavicular (Braquial plexophaty) and laterocervical zone (cervical nerves) was evaluate in our palliative care outpatient service for pain control. He was with transdermal fentanyl, corticosteroids and gabapentin with regular pain control. He has admission to the palliative care unit after 2 weeks and 1º switch to methadone because of the poor pain control and 1º started hyperalgesia. He 2º present hyperalgesia because of a rapid scale with methadone. We use in a 2º time Ketamine for 3 days and decrease methadone dose presenting better pain control for one week, after this we slowly increase methadone, presenting cardiorespiratory toxicity after 3 weeks. 3º switch to a regional analgesia with inthratecal delivery of morphine and low concentration of bupivacaine with acceptable pain control but started an urinary retention. 4º switch with morphine iv with maintained ketamine, NSAIDs iv and oral baclofen, with this treatment has the better pain control during long time but finally present for 3º time hyperalgesia without opioids toxicity and became the last 5º switch to fentanyl iv and terminal sedation with mydazolam iv and propofol iv
Conclusion: The exact mechanism of hyperalgesia with opioids toxicity or without opioids toxicity is unclear. It most be suspicious in patients who despite escalating doses of opioids has worsening pain. Successful strategies that may decrease or prevent opioid-induced hyperalgesia include the concomitant administration of drugs like NMDA-antagonists, NSAIDs or opioid switch.

PE 2.S334

Psychosocial support for children and their families

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Background: Malignant tumours are routinely diagnosed also in children. The results of their therapy are not dependent only on biological treatment, also the mental condition of the child and his/her social environment play an important role. Every month, the patients of the children's oncology department in Brno visit the zoo with their parents and the nursing and medical staff. The visits motivate the children to engage in various other activities, e.g., painting pictures. This program has been running for ten years already. The aim of the study was to get feedback from the parents whose children were included in the program.
Method: Twenty mothers and sixteen fathers of children with cancer were interviewed individually using a semi-structured interview guide. The interviews were tape-recorded for subsequent verbatim transcription. The data were analysed by the author using a qualitative content analysis without any predetermined categories. Both a manifest focus and a latent focus were used.
Results: The analysis revealed four manifest (descriptive) main categories: enjoyment, communication, relationship, and motivation. The first category had been expected: most people, either healthy or not, describe the visit to the zoo as pleasure or leisure. Visits to the zoo also improve communication and reinforce the relationship between children and the health care staff. Children are motivated to engage in other activities, e.g., painting or writing. The latent (interpretative) focus was on profound existential changes. The visits to the zoo symbolise health and hope.
Conclusions: Psychosocial support in the form of visits to the zoo is provided not only to ill children but also to children who went through successful treatment. The program includes also families, whose children died. I believe that this activity brings positive outcomes in the mental condition of the children and of the people who accompany them.

PE 2.S335

Palliative care for children and adolescents in German-speaking Switzerland: A needs analysis across three diagnostic groups

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Parents caring for their child with a life-limiting illness are confronted with a multitude of demands and have tremendous needs for support from health care professionals. Research on pediatric palliative care (PPC) in Switzerland is still in its infancy. To better develop concepts for PPC services, perceptions of care of affected families need to be examined. International studies on PPC often include only one group of diagnosis, e.g., mainly cancer, and are therefore not able to define differences in the needs of affected families with children suffering from neurological disorders or heart diseases. The purpose of this study was to identify the needs of parents caring for a child with a life-limiting illness depending on the diagnostic group.
Parents from three equally sized groups of diagnoses (n = 15) were interviewed:
(a) cancer,
(b) neurological disorders, and
(c) non-cancer/non-neurological conditions (e.g. heart diseases or metabolic disorders).
Interview questions regarded aspects of PPC such as communication with professionals, needs for support in the care at home or in the hospital, and bereavement care. Eligibility criteria were: active PPC at the time of data collecting and child's age between 1-18 years. Families whose child had died no more than two years ago were also included.
Parents of children with neurological and metabolic disorders expressed their needs and concerns in terms of an interdisciplinary care team. In Switzerland, psychologists and social workers in hospitals support children with cancer and their families, whereas children with neurological or metabolic diseases lack this support. Parents of children with cancer emphasized their need for an easy accessible and continuous bereavement care.
Acknowledging the needs of parents caring for a child with a life-limiting illness may lead to a better understanding of the different challenges for families and promote PPC services.
The study was funded by the Swiss foundation Pro Pallium.

PE 2.S336

The families' point of view on the respite offered in a children's hospice

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Problem: Even if respite is recognized as a fundamental element in paediatric palliative care, very few studies have examined the practices that concern respite in children's hospices.
Aims:
1) To better understand the meaning families give to respite practices that are set up in children's palliative care hospices.
2) To analyze the outcomes of these practices on different family members.
Methods: To meet the objectives of the study, the symbolic interactionnism theoretical framework and a qualitative methodology of a participative type were used. The data was collected with the help of many sources: semi-structured interviews with the parents who turned to the respite program in a children's

hospice (N=24 mothers and 8 fathers), individual interviews with children who benefited from respite stays in the hospice and who could express themselves verbally (N=10), participant observation periods of about three hours each in the hospice (N=20), and the consultation of intervention tools. To analyze the gathered data, we used thematic analysis.
Results: The parents appreciated the fact that their point of view and their child's point of view were taken into account in the course of the organization and the carrying out of the stay. Significant bonds can be created between families, the personnel and the volunteers. The respite stays can contribute to lessen the fusion between the parents and the sick child. They allow the parents to renew their energy, to regain hope and to concentrate on their other children. The stay allows the child to be stimulated in different ways and by different people.
Conclusion: Respite stays have positive effects on all of the family members. However, the parents point out that they must relearn how to take advantage of time for themselves.

PE 2.S337

Re-moving mountains: An exploration into the respite needs of adolescents/young people with life-limiting conditions as perceived by them, their parents and professionals from the multidisciplinary paediatric palliative care team

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Aim: This study aimed to explore the respite needs of adolescents/young people with life-limiting conditions as perceived by adolescents/young people, their parents/carers and professionals from the multidisciplinary palliative care team.
Background: Medical and technological advances have increased the life expectancy of many children/young people beyond the age of eighteen years creating a small but expanding group with no age or developmentally appropriate services, including respite.
Methods: A qualitative method was adopted, using unstructured interviews to elicit data from adolescents/young people (n=5) and their parents/carers (n=8), a focus group was facilitated to obtain data from the multidisciplinary paediatric palliative care team. Data were subjected to thematic analysis using Burnard's (1991) framework. Simple proformas were devised to obtain demographic information.
Results: Findings are consistent with earlier studies and indicate considerable inadequacies in present delivery of respite services. Emerging themes from the unstructured interviews were; respite services used, negative aspects of respite, positive aspects (benefits) of respite, transitional issues and desired future services. Three related themes were generated from the data from the focus group: holistic assessment and provision of respite, transition from child to adult services and development of an adolescent facility.
Conclusions: As this cohort of young people grows there is a need for increased and improved respite services which are age and developmentally appropriate, with flexible access to assist with crisis intervention. A multi-agency strategy for transitional care should be developed and implemented and the feasibility of the introduction of a hybrid youth worker and the establishment of a dedicated respite facility for adolescents/young people with life-limiting conditions.

PE 2.S338

When to introduce the pediatric palliative care team: The parents' point of view

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Aim: A major barrier to palliative care for children is the feeling caregivers have that the patient and family are not ready for it. The aim of our study was, therefore, to identify how families felt about the timing of their initial meeting with the palliative care team.
Methods: A survey was sent to the parents of children seen by the palliative care team of a tertiary pediatric university hospital between January 2001 and September 2006.
Results: Out of 95 families, 52 were located and 35 responded. Seventy-six per cent (76%) thought that the meeting with the palliative care team was held at the right time. None of them felt that the meeting should have taken place later. Sixty-seven per cent (67%) of the participants believed that it would have been helpful or very helpful to have met the team earlier. Forty-five per cent (45%) of the parents considered that they had not been correctly prepared for transition to palliative care. Most of the families said they would have found it helpful or very helpful: if the physician had informed them of the existence of the palliative care team very early on so the parents could choose when to meet the team (79%), if the physician had himself dealt with the risk of death earlier on (79%), and if written information on the palliative care team had been handed out on diagnosis (64%). The initial meeting with the palliative care team was followed by an improvement in the patient's quality of life in 48% of the cases and a deterioration in only 3% of the cases in spite of the progression of the disease.
Conclusion: The fear of harm should not be an obstacle to early frank communication about the risk of death and the possibility of being supported by a pediatric palliative care team.
Research funded by "Centre d´excellence en soins palliatifs pédiatriques du CHU Sainte Justine".

PE 2.S339

Experience of 2? years specialised paediatric palliative home care service

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Objectives: To determine requirements and feasibility for palliative home care in paediatrics.
Methods: During 03/2006 - 09/2008, 49 paediatric patients between 2 months and 27 years of age (mean 11,7), 17 female and 32 male, in palliative situation were supported by our specialised paediatric palliative home care team at home. Diagnoses were brain tumours (20), bone tumours (9), leukaemia (5), sarcoma of the soft tissue (5), neuroblastoma (3), nephroblastoma (1) and non-oncological diagnoses (6).
Results: Per patient, on average 8,5 home visits were necessary. Leading symptoms were pain (27), paresis (4), vomiting (6), impaired consciousness (5), dyspnoea (3) and spasticity (4). Up to now, 10/49 patients are alive, 39 died. 3 patients needed palliative sedation for symptom control, 11 developed critical situations, in 3 times with enlistment of an emergency physician. Beyond that, adequate symptom control could be achieved in nearly each patient, no patient was readmitted to hospital.
Conclusions: Anticipatory planning with drug prescription and detailed parental information, closely telephone contact to the families, routine home visits by the palliative home care team in cooperation with the family paediatrician and 24 hour on-call duty could avoid re-hospitalisation and unacceptable symptom exacerbation. Hence, specialised paediatric palliative home care service could enable affected families to spend the final time together with their child in a familiar setting at home.

PE 2.S340

Critical situations in paediatric palliative medicine - Experience of 10 years medical home care

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Objectives: To determine frequency and appearance of critical situations in paediatric oncological palliative patients in a medical home care setting.
Methods: All patients cared for by our specialised palliative home care service between 01/98-09/08 were registered and documented during their medical attendance. We reviewed our data concerning critical situations like haemorrhage, seizure, severe dyspnoea attacks, paresis, blindness, copremesis and superior inflow congestion.
Results: 102 children and adolescents were cared for in palliative situation at home. In 23/102 patients acute threatening events befalled. 3 children suffered a life-threatening haemorrhage, 5 an unanticipated prolonged seizure there of 2 with a status epilepticus. 7 patients developed severe dyspnoea attacks, 3 tetraparesis, 1 child went blind abruptly, 1 copremesis and 1 superior inflow congestion. In 3/23 cases an emergency physician was called for. Only 2 patients had to be readmitted to hospital.
Conclusions: The observed critical situations could be controlled either via order by phone or intervention at home. To prevent unacceptable exacerbation or re-hospitalisation an anticipatory planning, detailed parental information and 24 hour on-call duty by a paediatrician is mandatory. The needs and wishes of the children, adolescents and their families must be considered.

PE 2.S341

A situational diagnosis to analyse the reasons for referrals for consultation by a Paediatric Palliative Care Team

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The Paediatric Palliative Care Team (PPCT) was created in 1996 as part of the Oncology Team, mainly to provide care to children with cancer. After 10 years, PPCT redefined its profile to manage also non-oncological patients. Cultural, educational and subjective barriers to provision of PPC were identified in our institution. After the first year of work, PPCT wanted to perform a situational diagnosis in order to review the goals of the team. The Aim of the study was to describe and analyse motives behind referrals for consultation made by paediatricians to PPCT within our institution.
Material and methods: Descriptive study. A total of 218 reasons for referrals for consultations, relating to 139 patients aged from 0 to 18 years old were studied between months of August 2006 and August 2007.
Results: 218 reasons for referrals for consultation by PPCT from paediatric residents, internist and specialists, working in wards or with outpatients were analysed and categorised. Most frequent reasons were: pain relief, symptom control, diminishing sedation and opioid analgesia out of ICU, coping with illness trajectories, psychosocial aspects, assessment of patients with cystic fibrosis, support of "dysfunctional" families, psychological support, limitation therapeutic efforts and diagnostic/ prognostic information.
Discussion: Building a PPCT involves an asistential, educational and cultural challenge. A trend towards an increase in number of consultations, growing demands from professionals working with non-oncological diseases and emergence of requests from Intensive Care Unit (ICU) were observed. An educational strategy as a response to all demands was established in order to allow a gradual reduction of queries by non-specialised professionals in palliative care. In this first stage more acute diseases were assessed, hoping that in future PPCT could focus on its specific field, that being children with progressive diseases, end-of-life care and bereavement.

PE 2.S342

Withdrawn

PE 2.S343

Networking with volunteers for effective paediatric palliative care

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Introduction: Holistic Care for children with advancing disease includes physical, psychosocial and spiritual care. In developing countries, there is always a shortage of staff. At the Tata Memorial Centre, the team has included trained Volunteers for psychosocial issues for children and their families.
Materials & methods: The Palliative Care Unit at Tata Memorial Centre was formed in 1996.With the Doctors, Nurses, Social Workers and Clinical Psychologist, a group of Volunteers agreed to become part of the team. Before the inauguration of the Unit, they were trained in UK & Mumbai.
Observations: At the Paediatric Palliative care Unit at Tata Memorial Centre, we register 100 new children a year, with an age range from infants upto 25 years. The psychosocial issues encountered are wide and far ranging form economic, to lack of trained medical personnel in remote villages where patients reside. Along with the staff, all issues are discussed and gradually solutions are found from within the meager resources of the family. The loving, skilled care provided by the Volunteers often help Doctors and Nurses understand better the concerns of the child and family. The time they are able to provide has helped so many parents talk through their problems and find solutions. They are also a conduit for generous aid provided by the various NGO's in the city and elsewhere. Keeping in touch with the families after they have returned home, is also an invaluable resource, it helps doctors keep in touch with the Local Paediatricians and ensure good symptom control. Many families stay in the city to avail of our facilities.
Conclusions: In developing countries, Human resources are often limited, a group of dedicated skilled Volunteers, goes a long way in improving the care for children and their families who need effective Palliative care.

PE 2.S344

Organization of a new pediatric palliative care unit in Madrid: The challenge of an integral an integrated model

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Madrid is a state of Spain. The public health system has developed in the last years a program to offer palliative care to the adult population. In Madrid 400 children (age: 0-19 years) dye every year. 150 of them could receive palliative care.
Aim: In February 2008, we have organized an interdisciplinary team to offer paediatric palliative care to the population based on the IMPaCCT standards for Paediatric Palliative Care in Europe published in 2007. Our aim was to enhance the quality of life of the children and to support the family along the process of dying. We give direct palliative care in the hospital setting and at home and indirect palliative care, supporting other professionals at other hospitals and in the office setting. The challenge is to give palliative care to all the children, everywhere, every day, 24 hours a day. We are 2 physicians (paediatricians), one of them acts also as coordinator, 4 nurses, 1 social worker, 1 psychologist and a secretary. The child and the family choose the place of care. Patients or physicians can contact us by phone 24 hours a day.
Methods: A retrospective review of the children attended by the Palliative Care Unit from February 1st. to October 24th. The assessed variables were: Age, death, place of death and group of children by the EAPC.
Results: 36 children aged from 1 month to 19 years (mean 9,6 years) received palliative care. Group I (cancer)- 15 patients (42%); Group III (progressive neurologic or metabolic illnesses)- 9 patients (25%); Group IV (cerebral palsy and other)- 12 patients (33%). 17 patients have died. Place of death: 10 children (59%) could die at home accompanied by their family. .
Conclusions:
- The most of our patients are not oncologic.
- The majority of our patients could die at home with an adequate support by the team. We expect to increase the team, our quality of care, and to become a model for another states in Spain or another countries.

PE 2.S345

Extending a paediatric palliative care program for oncology patients to all children with life-threatening disorders

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Paediatric palliative care is a discipline that has his origin in haemato-oncology. A hospital-based home care program for haemato-oncology patients started in our institution in 1989. The philosophy of the program is to offer specialised and tailored home care to children and their family. Most children are suffering from rare, mostly oncological diseases, and care is given in liaison programs. The home-nurse, member of the hospital team, coordinates the care of the patient at home. The actual care is given by caretakers at home. The hospital team offers knowledge, structural and psycho-social support to the caretakers at home and to the patient and his family. This program was extended to include children without haemato-oncological disorders, since the year 2000.
Method: Evaluation of the patient population in the home care program between 2001 en 2007 at one institution.
Results: Between 2001 and 2007, an average of 37 palliative patients/year were followed (range 28-48). Most patients suffered from haemato-oncological problems (16/year , range 7-28). Patients with other diseases entered the program: neurological problems (11/ year range 4-19), metabolic diseases (3/year, range 2-4), cardiac disease, non malignant haematological disorders, respiratory , neonatal, nephrological and gastroenterological disorders.
Most children died at home: an average of 17 children died per year (range 8-31), a mean of 11 children died at home (range 6-18). Over the past years, as a trend, more children died at home.
Conclusion: Palliative care is an indispensable program in the care for children with rare and life-threatening diseases. Most paediatric palliative care programs focus on children with haemato-oncological disorders. It is important and necessary to extend this program to all children with life-threatening disorders.

PE 2.S346

Advance directives in pediatric palliative care

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Aims: Advance directives (ADs) are a commonly used instrument to support end-of-life decision making in adult palliative care. Some also advocate ADs for pediatric palliative care. Our aim was to explore how ADs could be used in a pediatric population and which caveats have to be respected.
Methods: In a pilot questionnaire study, we surveyed all physicians of our local Children's Hospital on their experiences and attitudes regarding ADs in pediatrics. Based on the results and a literature review, we performed an ethico-legal analysis.
Results: In the pilot study, 31% of the pediatricians reported having been confronted with ADs before. While 92% thought that this instrument is helpful, opinions were divided regarding which children should be included into the process of creating an AD and to what extent such a document could be binding with regard to treatment limitation. Generally, there are two forms of advance treatment decisions used in pediatrics, (1) classic ADs made by competent adolescents and (2) advance treatment plans (ATPs) created by parents and physicians in close cooperation. The first one raises the question how to define and assess decision-making competence and whether competent adolescents have the capacity to issue ADs. It also brings up the question of the relationship between adolescents' ADs and the parents' custodial rights. An ATP is a different kind of instrument, more a collectively agreed emergency plan than a unilateral treatment refusal. Here, the problem lies in the balance between the parents' custodial rights and the health care professionals' obligation to ensure the child's well-being. ATPs therefore only make sense as part of an ongoing communication process, which becomes manifest in characteristic formal features of ATP documents.
Conclusion: ADs are suitable instruments also in pediatric palliative care. However, there are significant differences compared to the situation of adults, and many problems have yet to be addressed.

PE 2.S347

Bana Pele - Children First: Developing a continuum of palliative care for children in resource-limited settings in South Africa

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Aim: To show that quality palliative care can be provided for children and adolescents despite lack of resources through community networking and involvement.
Methods: In South Africa 70% of children live in poverty. In the Motheo district of the Free State, an assessment showed that around 50 000 children require palliative interventions with 1 200 receiving these. Children under 4 years are the group with the highest mortality rate. Where resources are limited, children die of malnutrition, HIV-related infections, diarrhoeal diseases and tuberculosis. Palliative care services for children increase identification of vulnerable children; get children onto anti-retroviral therapy, anti-biotoics, nutritional therapy and cancer threrapy, thus improving quality and length of life. Four children´s hospices, located in Johannesburg, Cape Town, and Bloemfontein have developed networking partnmerships with government health and social services, other non-governmental organisations, businesses and faith-based organisations to identify children needing palliative care and treatment .After assessing these programme s a model was developed for the Motheo District called St Nicholas Bana Pele (a South Sotho term meaning Children First) Network, to set up a safety network of services with a strong referral system, so that all resources required to improve the quality of life of children in any children´s service, will be collated for each child; children with HIV and other health needs receive early assessment and referral for treament. and families receive support in caring for the children and accessing social services.
Results: Assessment of different successful children´s palliative care services in resource-poor settings, led to an effective new model. in a resource-poor area of South Africa.
Conclusions: A strong network of serevices increases identification of life-limited children and improves access to care and treatment.

PE 2.S348

Developing a palliative care strategy for children and adolescents in South Africa

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Aim: To improve access to quality palliative care for children in South Africa.
Methods: Assessment of the status of children´spalliative care in South Africa showed few children´s hospices, little understanding of the difference between children´s and adult palliative care,

few funding resources for children´s palliative care, and a dearth of materials suitable for Africa. Working together with individuals working in the field from 6 African countries, materials were developed for use in hospitals, hospices and communities, and a toolkit for the development of children´s palliative care . individuals in hospices in South Africa were identified, to form a national committee to take these into each province of the country with the primary aim to integrate children´s palliative care into hospices that were mainly focussed on adult palliative care. Two national paediatric staff were appointed and supported by the committee were able to establish 18 new children´s palliative care sites in one year, with a further 22 initiated in the second year. the objective of the project is to ensure thta staff in every hospice and palliative care service in South Africa has the necessary skills to identify children with life-limiting and chrnic conditions, assess pain and symptoms, communicate effectively with children and provide child-friendly services. An introductory course has been developed with a project to implement an advanced course in progress.
Results: Skills and knowldege in children´s palliative care were increased in members of the committee and hospices. Materials were developed suitable for the South African context. Awareness about children´s palliative care was increased. A further 30 hospices have asked for support to include children´s palliative care in their services, with 22 identified for further development.
Conclusion: Increased knowledge leads to hospices being willing to provide children´s palliative care within traditionally adult services.

PE 2.S349

Effectiveness of a coordination center for pediatric palliative care: The parents' experience

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Background: The home care of severely ill and dying children is still at its initial stage. The Coordination Center for Pediatric Palliative Care (CPPC) at the University of Munich strives to enable the care of dying children at home with a good quality of life through coordination of all professional assistance in the palliative phase as well as a 24/7 medical on-call service.
Methods: Parents of children cared for by the CPPC were contacted at the earliest 3 months after the child's death. They were sent a self-developed questionnaire asking about their satisfaction with various aspects of the CPPC's work and with the course of the dying phase (using numerical rating scales, 0-10). Validated questionnaires (HADS, PG-13) were used to probe for anxiety, depression and prolonged grief disorder.
Results: 43 parent dyads agreed to participate, the questionnaire return rate was 88%. 37% of the children died of an oncological disease. The mean duration of care by the CPPC was 6.5 wks [0.1-48.1]. Mean satisfaction with the CPPC's work was 9.1 [4-10]. The importance of the 24/7 on-call service was rated highly (mean 9.4). The child's death had been experienced as very peaceful in most cases (mean 8.4). 71% of the children died at home. According to the parents, involvement of the CPPC led to a reduction in the children's symptom load (median 10 vs. median 8; p<.001) and to significant improvements in the children's quality of life (md 3 vs. md 7; p<.001) as well as in the communication within the caring team (md 6 vs. md 9; p<.001). Anxiety was detected in 25% of parents, depression in 19%. 5 parents developed a prolonged grief disorder.
Conclusions: Involvement of the CPPC, according to the parents' opinion, led to a marked improvement in all domains of care investigated. Thus, coordination of the health care professionals involved in the last phase of life appears to be a pivotal quality factor for the home care of dying children and their families.

PE 2.S350

Extubating children at home or hospice for end-of-life care - What´s involved?

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Aim: To identify the key services and drugs needed to support patients and parents when transferring a child on respiratory support home or to the hospice for extubation and end-of-life care.
Methods: A retrospective case series review of 6 children who were transferred from the paediatric intensive care unit at Great Ormond Street Hospital.
Results: 4 children were transferred to a hospice and 2 were transferred home for extubation. The time taken to set up the transfer ranged from 6 hours to 3 days. Key people involved in supporting the family with decision making whilst on intensive care and at the place of extubation are identified. We also identified the most common drugs used during the transfer and post-extubation.
Conclusion: Extubating a child outside of hospital requires several supporting services to work together. Co-ordinating all the services and medications takes time and tremendous committment from individual practioners.

PE 2.S351

Effectiveness of a coordination center for pediatric palliative care: The health care professionals' experience

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Background: Pediatric palliative care in the home setting is a challenge for all involved health care professionals (HCPs). The goal of the Coordination Center for Pediatric Palliative Care (CPPC) at the University of Munich is to improve the networking of the multiprofessional resources involved in each child's care by targeted care coordination. This study's objective was to monitor the effectiveness of the CPPC's approach as perceived by the involved HCPs.
Methods: Preliminary interviews elicited factors regarded as important for successful pediatric palliative care. A questionnaire with numeric analog scales (0-10) was developed and sent to HCPs (physicians, nurses, social workers, psychologists, chaplains, physiotherapists etc.; N=105) which were involved at least once in the palliative care of a child cared for by the CPPC.
Results: The return rate was 83% (N=87; 51% physicians, 28% nurses, 22% other HCPs). All care domains investigated improved significantly after involvement of the CPPC (p<.001), particularly the cooperation with the local physician (median 5 vs. median 7) and the hospital doctors (6 vs. 8), the communication within the multiprofessional care team (6 vs. 8), the networking with external care facilities (5 vs. 8), the funding of the home care (5 vs. 7) and the support of the whole family (6 vs. 8). 35% of respondents feel rather uncertain in pediatric palliative therapy and symptom management, 30% in ethical/legal questions. 40% of HCPs report a deficiency of psychosocial support for the caring team, and 79% would welcome advanced training possibilities in pediatric palliative care.
Conclusions: Involvement of the CPPC in the home care of dying children is experienced as a substantial improvement by all HCPs involved. The main areas of perceived improvement are cooperation between the different HCPs, assistance for the child and reduced burden for the family. There is a high demand for training opportunities in pediatric palliative care.

PE 2.S352

Developing a tool for spiritual assessment of life-limited children in South Africa

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Aim: To provide a culturally relevant assessment tool for children in South Africa. Palliative care for children includes spiritual assessment and care, but this is often neglected due to lack of skill in assessing children´s spirituality and lack of understanding of spirituality in children.
Methods: Literature search revealed most literature has been developed for the developed world. Assessment of knowledge, skills and comfort of palliative care practitioners in a children´s hospice through a questionnaire and follow-up interviews. Participants were asked to rate their ability to assess children´s spirituality and to provide spiritual care and support. 20 Children between 5 and 12 with competent verbal skills were interviewed on what their life meant to them, how the perceived themselves in relation to others; and their concept of themselves. Caregivers were interviewed on each child´s ability to interact with other children, participation in religious rites, and self-awareness. A simple assessment instrument was developed and tested in four sites with 50 children and their caregivers, taking into account certain cultural beliefs and practices.
Results: Once caregivers realised that spiritual assessment and care if life-limited children did not require in-depth theological knowledge, they participated actively in testing the instrument. Children were all willing to answer the questions and to speak of their beliefs.The tool was easy to use.
Conclusion: Children express their spiritual oncerns in many ways - through art, play and in narrative form. Those caring for them can be taught to assess the child and provide support through using a simple assessment tool and reacting to the child´s spiritual needs.

PE 2.S353

Palliative care needs of nursing home residents in Germany

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Aims: New legal regulations in Germany make palliative care in nursing homes a right for all patients. Our study aims to explore the palliative care needs of nursing home residents in Germany.
Methods: Using a qualitative exploratory design, we carried out semi-structured interviews (n=14) with residents and their significant others, general practitioners and palliative care specialists and performed focus-group discussions (n=2) with nurses, social workers and volunteers. The interviews were audio-recorded, fully transcribed and analyzed by grounded theory approach. Our sample was purposeful; residents with impaired communication capacity were excluded.
Results: Results show that enough time, continuity of care and a trusting relationship between the resident and the nurse(s) are prerequisites for residents to address their needs. Psychosocial issues are: to be in contact with family, friends and "the world outside", need for closeness to loved ones, reconciliation with family members, need to say good-bye, need for control over therapy and care, need for consultation concerning the living will. Physical issues are: pain, wound care, breathlessness, weakness, need for rest, need to go outside to get fresh air, exsiccosis, constipation, cachexia, dizziness, tube feeding. Lack of cooperation between general practitioners and palliative care specialists preclude adequate symptom relief. Spirituality serves as a helpful resource, especially when dealing with crisis and dying.
Conclusions: Shortage of nursing staff leads to retreat of nursing home residents. Good staffing is essential to meet the needs of this population. An integrated approach considering psychosocial, physical and spiritual needs is necessary. Specialised palliative care teams should back up primary care.

PE 2.S354

Affective disorders among the patients of a hospice

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Introduction: Basic destination of medicine is deliverance from suffering. This postulate becomes especially relevant in the area of palliative ??re, because at the end-of-life many medical decisions are determined by personal values and individual needs of a patient.
Objective: To estimate the prevalence of affective disorders among terminally ill cancer patients in a hospice.
Materials and methods: 49 patients (19 male and 30 female, mean = 73,17±7,13 yrs) hospitalized due to incurable oncopathology for palliative care in the hospice were questioned according to Hospital Anxiety and Depression Scale (HADS) and Geriatric Depression Scale (GDS-15). The inclusion criterions were the ability to understand the text of the questionnaire and the wish to answer to one. For making a diagnosis of depressive disorders, the clinical interview has been hold by the psychiatrist after the score psychodiagnosatic scales.

Results: Depressive disorders have been detected in 69,39% patients (male 68,42%, female 70,0%). According to ICD-10 diagnostic criterions the revealed disorders were classified as organic affective (depressive) disorder (F06.36),n=9;18,37%, recurrent depressive disorder (F33.11), n=10; 20,41%, current depressive episode (F 32.0), n=4; 8,16%, dysthymia (F 34.0), n= 4; 8,16%, depressive reaction (F 43.0), n = 7;14,29%.
Conclusions: High prevalence of depressive disorders (69,39%) was estimated in patients of the hospice. Use of psychodiagnostic questionnaires for screening revealing the depressive disorders is purposeful and has a number of considerable advantages in this age group:
1) doctor obtains quantitative rating of severity of depression and anxiety;
2) patient has a possibility to express verbally his/her mental experiences that can remain without attention during an ordinary somatic examination;
3) medical staff acquires experience of more empathic response onto emotional needs of the patient.

PE 2.S355

The voices of older people living in supported 'extra care' housing about end of life care

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Background: 'Extra care' housing is a model of supported housing that provides assistance while preserving some independence for frail older people, many of whom have palliative care needs. This study took place in collaboration with a national provider of extra care housing in England.
Aim: To explore the views of older people living in supported housing about end of life care issues.
Method: Two extra care housing schemes in the North of England were recruited. Twenty-seven older people attended informal 'coffee morning' meetings at which they expressed a range of views about end of life care. These were recorded in written field notes. Six older people (five women and one man) four of whom rated their health as 'fair' or 'poor' took part in individual interviews. Field notes and interview data were analysed using a framework approach.
Findings: At the informal meetings, some older people said that the topic was not relevant since they hoped to live for a 'long time yet'. Others said they thought about the end of life a lot, but did not talk about it. A number recounted bereavement or illness experiences. In the individual interviews, participants stressed the desire to live in the housing facility until the end of their lives. A key concern was to relieve their families of burden. For some, the choice to live in extra care was a form of advance care planning.
Conclusion: Extra care housing providers face challenges in providing care to their residents until the end of their lives. These findings have implications for all providers of supported housing.
Funding: Burdett Trust for Nursing.

PE 2.S356

A definition of Geriatric Palliative Medicine

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Aim: As dying trajectories for frail older are quite different from those of younger patients, palliative care for this population will need specific skills. The purpose of this project is to define the specific aspects of Geriatric Palliative Medicine (GPM).
Methods: The Geriatric Palliative Care Interest Group of the European Union Geriatric Medicine Society met to discuss a definition of GPM. They rely on the WHO definition of palliative care and the existing definitions of Geriatric Medicine.
Results: GPM is the medical care and management of older patients with health related problems and progressive, advanced disease, for which the prognosis is limited and the focus of care is the quality of life. Therefore GPM:
- combines the principles and practice of both geriatric medicine and palliative care
- focuses on comprehensive geriatric assessment, relief from pain and other symptoms and management of physical and psychological problems, integrating social, spiritual and environmental aspects
- recognises the unique features of symptom and disease presentation, the interaction between diseases, the need for safe drug prescribing and the importance of a tailored multidisciplinary approach for older palliative patients and their family
- emphasises the importance of autonomy, the involvement in decision making, the existence of ethical dilemmas
- calls the need for good communication skills when discussing and giving information to older patients and their families
- addresses the needs of older patients and their families across all settings
- pays special attention on transitions in and between settings of care
- offers a support system to help the family cope during the patients illness and in their own bereavement.

Conclusion: Defining Geriatric Palliative Medicine is the first step in an attempt to address the important topics of GPM, to discuss the relevant issues and to plan strategies to improve the care for older patients at the end of life.

PE 2.S357

Pain assessment and management in the home: Perspectives of older patients with advanced cancer and their family caregivers

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The evidence indicates that significant numbers of people with advanced cancer suffer with pain. Moreover, prevalence rates indicate that older people in particular are likely to have their pain inadequately assessed and treated. With a move towards home care, there is greater reliance on family caregivers to assume added responsibilities with regard to symptom management in palliative care; a task that can be extremely challenging. Family involvement in pain management can include assessment, monitoring, administering medications and non-pharmacological approaches, negotiating with health professionals, acting as a proxy on behalf of patients, and decision-making regarding treatments. Therefore, key to understanding barriers to effective pain assessment and management, within this context, are the perceptions of both the patient and their family caregiver. To date, studies have predominantly used quantitative methods to understand factors affecting the management of pain. Yet qualitative approaches can provide insights into the complexity of the phenomenon from different perspectives. The aims of the study were to explore pain assessment and management from the perspectives of older patients with advanced cancer receiving home palliative care and their family caregivers. An inductive qualitative content analysis was used to describe and interpret the data collected from 15 patients and their caregivers. Measures were taken to ensure methodological rigor. Areas explored included symptom communication, expectations, assessment, roles in decisions regarding pain, coping, challenges dealing with pain at home, and their views on professional support. The findings provide insight into the experiences of pain in older adults and characteristics of the context of care that facilitate or impede the recognition and effective treatment of pain.

PE 2.S358

The role of the cancer experiences collaborative in the development of research capacity in supportive and palliative care for older adults: A progress report

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Background: Since 2006, the Cancer Experiences Collaborative (CECo), a partnership between five UK universities, has developed research capacity in supportive and palliative care. One theme of work focuses upon care for older adults towards the end of life, reflecting recognition by the palliative care and public health disciplines that care in the last year of life for older people is an important priority. **Aims:** The Older Adult theme aims to address aspects of older adult's experiences previously under researched. It also considers methodological issues, including how to involve service users in the research process.
Methods: We have held a series of 'protocol generation events' bringing together collaborators (researchers, clinicians, service users) to develop research proposals. These have been supported by 'State of the Science' meetings at which are presented new findings and cutting edge work in the area.
Outcomes: An interdisciplinary programme of work has been developed that focuses upon three core areas: older people's priorities, processes of care and places of care. Specific focus is paid to older adults living alone, care homes and family carers. To date CECo members and collaborators have obtained 15 research grants worth just over £2 million. A series of four funded seminars addressing 'Psychological and Social Aspects of Dying in Old Age' have been undertaken involving over 130 academics, clinicians, older people and voluntary sector organisations.
Conclusions: It is possible to develop a collaborative programme of supportive and palliative research focused on the needs of older adults that has relevance for clinical practice, policy makers and future research development. However, appropriate time and resources are required.
Funding source: NCRI

PE 2.S359

Developing a palliative care intervention in advanced dementia: Methodological challenges and solutions

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Introduction: The quality of end of life care received by patients with advanced dementia and their carers is often poor. Families are rarely informed of likely outcomes but are expected to make difficult end of life care decisions. The aim of this study was to design and pilot an intervention to improve care.
Methodology: Using the MRC framework for complex interventions, this phase II study intervention consisted of a palliative care needs assessment and advance care planning (ACP) (delivered by a nurse-specialist) to enhance relatives' understanding of end stage dementia, support their decision making, reduce unplanned emergency hospital admissions and improve satisfaction with care. We aimed to recruit 80 relatives of patients with advanced dementia, admitted to acute hospital wards, clustered at ward level ("usual care" on one ward and intervention on the other).
Results: Difficulties with recruitment became apparent as 33% of patients did not have an available next of kin and families (particularly the control group) were reluctant to participate in research during the acute hospital admission. The protocol was amended to allow potential participants to be identified during the critical time of hospital stay, but for the research to be carried out in the community. This allowed randomisation of all patients into either the intervention group (palliative care needs assessment and ACP) or the control group (information pack related to care needs). Overall, relatives found the intervention useful; ACP has been completed so far by 26%. Reasons for non completion included complicated family dynamics and reluctance to address end of life issues or make decisions. The intervention appears timely as 40% of patients with advanced dementia died within 6 moths from the hospital admission.
Conclusions: Recruitment on acute medical wards is methodologically challenging, therefore community recruitment may be better. The intervention has been overall well received.

PE 2.S360

Bridging the gaps between palliative care, gerontology, and mental health: A collaborative initiative to improve the care of delirious patients at the end-of-life

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Aim: To present the impact of a collaborative partnership across healthcare spheres to improve the care of patients with delirium at the end-of-life.
Methods: In May of 2006, evidence-based interdisciplinary guidelines on delirium in seniors were released by the Canadian Coalition for Seniors Mental Health (CCSMH). Concurrently, two Canadian research teams in end-of-life care were identifying delirium as a pressing issue in palliative care service delivery. A partnership was thus formed between the CCSMH and the research teams to adapt and implement the delirium guidelines specifically to an end-of-life care context. A workshop held in January 2008 brought together multidisciplinary clinical experts and researchers in palliative care, geriatrics and mental health. The CCSMH guidelines were reviewed, and many of the guidelines were revised based on existing evidence on delirium in palliative care.
Results: This project illuminates the possibility for partnership across different domains of health service delivery, and simultaneously underscores the unique nature of the end-of-life care context. Aspects of this ´uniqueness´ include the fundamental importance of clarifying goals of care at the end-of-life and of viewing the patient´s experience as constitutive of a psychosocial history and relational connectedness to family. Also, the evidence base for recommendations retained from the original guidelines was sometimes lowered, indicating the relative dearth of empirical research data specific to palliative care settings.
Conclusion: Quality care for people at the end-of-life depends on collaborative partnerships across health sectors. Based on the revisited guidelines, next steps in this project include the the development, implementation and evaluation of care pathways for delirium at the end-of-life for patients across varied end-of-life care contexts (e.g. hospital, hospice, and home).

PE 2.S361

Trend in treatment of pneumonia among Dutch nursing home patients with dementia, 1996-1998 versus 2006-2007: More treatments to relieve symptoms

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Aim: Interest in dementia palliative care has expanded recently due to demographic developments and acknowledged care deficiencies. To test if palliative care for dementia patients is improving, we compared treatments in cohorts of patients with dementia and pneumonia a decade apart.
Methods: In two nationwide studies in the Netherlands, 61 (1996-1998) and 54 nursing homes (2006-2007) participated, of which 53 were the same. In 1996-1998, 706 patients with pneumonia and dementia were prospectively enrolled by 201 physicians and in 2006-2007, 72 patients by 69 physicians. Data collected included treatments, physician and patient characteristics, outcome, and in the 2006-2007 study, physicians' self-reported change in treatments.
Results: The frequency of providing antibiotics was similar: 79% in the recent cohort versus 77% 10 years before (p=0.63) as was oral antibiotic treatment (91% of those receiving antibiotics versus 88%; p =0.44). Treatments to relieve symptoms that were provided more frequently were, for example, antipyretics (54% versus 34%; p=0.001), oxygen (29% versus 13%; p<0.001), and opiates (22% versus 10%; p=0.003). Differences were not explained by different case mix. Half of physicians (49%) stated they generally treat to relieve symptoms more frequently than before.
Conclusion: In the Netherlands, nursing home physicians provide more symptom relief to patients with dementia and pneumonia compared to a decade ago while maintaining similar levels of curative treatments. Further cross-national studies are needed to detect if improvement in palliative care in the understudied dementia population is a general trend.

PE 2.S362

Referral of terminally ill patients to medium-long term hospitals and residential care centers in Extremadura

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Background: From 2006, Extremadura implemented medium-long term care hospitals and residential care programmes and resources covering both health and social care of terminally ill patients.
Aim: To know the number of terminally ill patients referred to social-health centers in Extremadura from Palliative Care Teams (PCTs), its social-health profile and the elapsed time from the patient's inclusion in the program until the referral to centers.
Method: Retrospective observational descriptive study. The clinical files of all terminally ill patients registered by the 8 PCTs in Extremadura during 2007 were revised.
Variables: Social-demographic characteristics, number of patients referred by PCTs to medium-long term hospitals and residential care centers in Extremadura, elapsed time of referral to them (days).
Results: 1,711 clinical stories from the PCTs (n=8) have been studied.
The number of patients referred to medium-long term centers of Extremadura in 2007 by palliative care teams has been 54 patients (3.15%).
The social-demographic profile is a male (65.1%) with an average age of 75 years with main diagnostic being cancer (81.5%) with primary level studies (59.2%), regular economic situation (46.1%), social network breakdown (70.8%). Regarding carers, the vast majority were sons and daughters (37.9%). The elapsed time average in patients' referral process was 41 days.
Conclusions: The number of patients referred to medium-long term centers in Extremadura is poor (3.15%), with a long waiting time for referral (average: 41 days). In referred patients, we must stress the social needs profile such as the fact that the main carer are the sons and daughters and the vast majority of patients showed a breakdown in their social network.

PE 2.S363

Palliative care for elderly people with pressure ulcers: Lessons we have learned and challenges for the future

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The life expectancy of people increased. Older citizens still require more care and needs in comparison with younger populations. Among elderly population conditions such as cardiovascular and neurological disorders and its complications are now leading causes of bed bound and death. Pressure ulcers are the first complications in those who are bed bound. As pressure ulcers occur the complications such as infection, dehydration and malnutrition appear. This complications increased oxidative stress and other metabolic conditions.
Aim: Was to investigate the metabolic condition and oxidative stress markers among elderly people with pressure ulcers.
Methods: Newly admitted elderly patients (n=29, age 62-93) to Home Hospice For Adults Of Association Of Volunteers Of Palliative Care In Wielkopolska were assessed blood pressure, waist, pressure ulcers (Thorrance scale), feeding status (MNA) and after overnight fasting metabolic factors: erytrocytes sedimentation rate (ESR), complete blood count (CBC), concetration of total protein, glucose, plasma lipids: total cholesterol (T-C), HDL-cholesterol (HDL-C), LDL-cholesterol (LDL-C), triacyloglicerydes (TAG), level of glycated hemoglobin (HbA1c) and activity of superoxide dysmutase (SOD-1) were estimated. According Thorrance scale we divided patients into two groups: with the better Thorrance 1,2,3 stage (B) (n=16) and worseThorrance 4,5 stage (W) (n=13).
Results: 1. All patients were malnourished (MNA 5 or lower) and did not differ with the ESR, CBC, total protein, glucose, lipids profile and HbA1c.
2. The SOD-1 activity was dramatically low (p<0,03) in W (1011±324 U/gHb) vs. B (1322±391 U/gHb) 3. Negative correlation was found for SOD-1&Thorrance scale (R=-0,39 p=0,036).
Conclusions: Because Thorrance scale correlate with the intracellular antioxidative marker SOD-1 we suggest that for patients with pressure ulcers Thorrance assessment is sensitive and specific risk stratification tool and may be used as the best tool.

PE 2.S364

A specialist palliative care service for patients with advanced dementia: an analysis of the first 50 patients

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Specialist palliative care has been wary of end-stage dementia because of its long slow progression, a fear of inundation, difficulty in identifying the terminal stage, and a lack of a suitable model of care. This is an interim report of the first 100 referrals to such a service, provided by an experienced specialist palliative home care nurse (CNS) with consultant support. UK Gold Standards Framework (GSF) referral criteria were adopted, plus a modified surprise question: would you be surprised if this patient died within 6-12 months? 1 referral was received every 8.1 days from many medical and social care professionals. Most were for symptom control or carer support. 68% were in residential care, 31% at home, 1% in hospital. 9 were rejected, 7 died before being seen, 88% were accepted (including 4 rereferrals). 15 were stabilised and discharged, 55 died under the service within 18 months of inception; the rest were still being seen at review. Common symptoms were weight loss, fatigue, weakness, anorexia, drowsiness, aspiration, constipation, and sleep problems, the first 5 being most severe. A few had complex symptoms. Pain was present in 71/88 , usually from arthritis, pressure sores or contractures, incident or procedural pain. Only 5 required the equivalent of 60mg oral morphine / 24 hours. Only 3 briefly needed the full palliative home care service, at the end of their life. 10 patients were admitted to hospital, where 8 died; 1 admission was inappropriate. Most patients can be cared for by generalists.. However specialist palliative care support had a key role in identifying dying, enabled carers to pick up symptoms in uncommunicative patients, referred to appropriate outside agencies, identified those needing specialist input, communicated with families, educated and mentored professionals, monitored end of life care and screened bereavement issues. GSF criteria seem useful; formal validation is being carried out. This model of care appears cost-efficient .

PE 2.S365

Hypernatriemia at admission in elderly patients implies a dismal prognosis, even with adequate rehydration

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Aim: In elderly care several guidelines are developed for treatment of hypernatremia . Its prognostic significance is however unknown.
Patients and methods: We conducted a retrospective analysis among patients over 70 years of age, with sodium levels equal to or greater than 150 mmol/l (at admission or during the hospitalization). All admissions from jan 2007 to oct 2008 were screened for the presence of hypernatremia. In cases with serum Na >150meq/l; individual charts were drawn and date of death or hospital discharge were noted. 82 patients had a serum sodium of >150meq at admission, all were

treated with hypotonic fluid (always 4 liters of Glucose 5% over 24hours until normalisation of serum sodium).
Results: Hypernatremia was found in 82 patients. Mean age was 84.1 ± 6.7 years. The mean peak serum sodium level was 157.3 ± 7.4 mmol (ranged from 150 to 188). Most of the patients had severe dementia. In spite of fluid replacement and follow-up treatment, outcome was poor: 40 patients or 50% died within 2 months.

Sodium value	number median	survival (range)
150 - 155	25	14 (1 -60days)
156 - 160	9 7	(1-32 days)
161 - 170	4	50 (37,64)
171 - 175	2	7 days
176 -180	1	4 days
>180	1	1 day

Conclusion:
1. Elderly patients admitted with hypernatriemia, have a dismal prognosis: 50% die within 60 days of admission; even with normalisation of sodium.
2. prognosis is inversely related to the degree of hypernatremia; above 170mmol prognosis is < 1 week.
3. Our data illustrate that intracellular dehydration is part of the natural dying process of the elderly with dementia. Even vigorous artificial rehydration does not alter this natural process nor its prognosis.

PE 2.S366

Evaluation of the Gold Standards Framework for Care Homes: The development of a matrix to analyse qualitative data

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Aim: End of life tools such as the Gold Standards Framework for Care Homes (GSFCH) are recommended as a means of improving palliative care in care homes. As part of a larger intervention and evaluation study of GSFCH in 7 care homes, qualitative interviews were conducted with relatives and care homes managers. The aim was to explore any changes in the quality of end of life care delivered to residents and their families as a result of implementing the GSFCH.
Methods: A total of 36 semi-structured interviews took place with relatives, 22 before implementation of GSFCH (20 declined) and 14 after implementation (14 declined) Semi structured interviews were conducted with 6 of the 7 care home managers after implementation. A realistic evaluation approach was adopted. All interviews were fully transcribed and analysed thematically using NVIVO qualitative software. The relatives' interviews were also scrutinised for 'instances of care' in relation to the 7 C's of the GSFCH: co-ordination, communication, control of symptoms, continuity, continued learning, carer support (family and staff), care of the dying. The 7C's were designated as having positive, negative or equivocal outcomes. A matrix corresponding with the 7C's of the GSFCH was used to identify any changes in these salient areas post intervention.
Results: Post intervention the number of positive outcomes increased and the number of negative outcomes reduced suggesting that overall the project had a positive impact in terms of the 7C's. When the data is analysed across all the care homes there are improvements in the following areas: care of the dying, control of symptoms, continuity of care, carer support (families) & continued learning.
Conclusion: There was an improvement in the quality of end of life care delivered from the perspective of bereaved relatives. The analysis matrix developed was a novel approach and could be further adapted for the evaluation of end of life care tools.

PE 2.S367

Feeding difficulty in elderly with dementia. Supporting nursing home nurses in the decision making process

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The aim of this project is directed at supporting nurses to actively participate at the decision making process about care and treatment of elderly patients with advanced dementia in a nursing home ward.
Design and methods: In the first stage of the project qualitative data were obtained by means of interviews with nurses about their experience with patients refusing to eat or drink and through participation and observation. In the second stage a literature review was performed. In the final stage interventions will be implemented and evaluated.
Findings: The results from the qualitative interviews indicate that nurses are deeply involved with the care of the patients. Information about patients' wishes concerning the end-of-life is important for nurses in order to be able to cope with patients' refusal to eat or to drink.
Even if nurses are highly motivated to contribute to the quality of life of the patients they hesitate to report their observations and more clearly to discuss patients wishes during the decision making process about patients treatment. By this they didn't succeed in achieving the proper treatment for the patient, which may lead to increased patients´ suffering at the end of life.
Insights from the literature review lead to adopt the advocacy model of Curtin and two instruments in order to support nurses to report concrete observations of patients' behaviour and feeding refusal.
Conclusion: The first results of this project indicate that nurses are enthusiast about learning to act as an advocate of the patient and to report concretely their observations. By enhancing nurses´ awareness and feeling of security they will be encouraged to actively participate at the decision making process and to contribute more completely to the quality of the end-of-life of patients with advanced dementia.

PE 2.S368

Symptom prevalence in the last year of life of Brazilian underprivileged elders: A palliative care needs assessment

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Brazilian elderly population is growing faster than any other age group and is expected to be around 32 million in 2020 (the 6th in the world). As a consequence, more and more people are suffering with chronic conditions and enduring complexes of symptoms near the end of life. This study aimed at interviewing family caregivers of recently deceased elders to investigate the presence, severity and duration of 14 distressing symptoms, as well as whether they were managed during the last year of life.
Elders were enrolled to a population-based cohort study in deprived areas of western Sao Paulo. Any death from the cohort was eligible for the present study. Three months after death (minimum), the interviewer identified the best informant for the last year of the deceased and invited him/her to participate. Data were collected at the place of the elder or caregiver, using a questionnaire about the symptoms: pain, fatigue, dyspnea, depression, anxiety, insomnia, easy-crying, anorexia, nausea, constipation, dyahrrea, pressure sores and urinary/fecal incontinence. Deadline for interviewing was 16 months pos-death.
Eighty-one caregivers were interviewed. Mean age was 78 among the elders (41 female). The most prevalent diagnoses at dying were cancer, pneumonia and stroke. The most prevalent symptoms at the last year were pain (78%), fatigue (68%), dyspnea (60%), depression and anorexia (58% each). Pain, dyspnea and fatigue were the most severe. Pain, fatigue and depression lasted more than 6 months. The most prevalent in the last week were fatigue, urinary incontinence, anorexia, dyspnea and pain. Management of pressure sores was regarded as inefective in 46% and of pain in 45% of the cases. No treatment was received for depression (79%), urinary incontinence (77%) and anxiety (67%).
High prevalences of symptoms were found. It´s mandatory to spread the concepts/actions of long-term and Palliative Care to provide Brazilian elders with dignity and quality at the end of life.

PE 2.S369

Diseases coexisting with cancer in patients of advanced age provided with home palliative care

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Aim: Most palliative patients are people of advanced age and take various medications for many years because of chronic internal, neurological and other medical problems. When planning a therapy for a patient who was treated for already existing diseases before, palliative care specialists face the problem of choosing the safest therapy necessary to control developing cancer. Proper therapy for several diseases should be based on an in-depth analysis of all drugs that are necessary and it should also consider potential interactions and costs.
The study aim was to define the age structure and identify chronic diseases coexisting in home palliative cancer patients.
Methods: Non-clinical and non-invasive research based on 208 advanced cancer patient's medical documentation from the Non-Public Home Palliative Care Institution in Lodz. The analysis did not include documentation, which were shorter than 7 days of care. All the patients required symptomatic treatment. Research selected coexisting diseases were the ones for which patients took medication.
Results: The age of patients was between 25 and 90, elderly patients were in the majority.
The most frequent cancers diagnosed were: lung, breast and digestive system cancers. Coexisting diseases were diagnosed in 79,2% patients the most often were diagnosed diseases: circulatory system diseases, ischemic heart disease, hypertension and peripheral vessel disease, and very common disease - about 25% of patients was diabetes type II. Patients reported 1-4 coexisting diseases, maximum 7.
Conclusions:
- patients provided with home palliative care were people of advanced age
- most patients suffered from coexisting diseases
- most frequent diseases coexisting with cancer are ischemic heart disease, hypertension, peripheral vessel disease and diabetes
- estimation of costs of treatment for palliative care patients should also include treatment of coexisting diseases.

PE 2.S370

The birth of a death plan: The origins of an advance care planning tool for improving people's experience of end of life

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Aim: The national End of Life Care Programme (2004-2007) in the UK supported 3 major initiatives for improving end of life care, one of which was the 'Preferred Priorities for Care' (PPC; formerly named 'Preferred Place of Care'). PPC is a patient-held advance care planning document intended to help patients facing serious illness and end of life. The aim of this study, as part of an evaluation research programme of PPC, was to explore and document the origins of this initiative.
Methods: We conducted and audio-recorded semi-structured interviews with the four key people involved in the origination of the PPC initiative. The interviews were transcribed and analysed to develop a coherent account of how the initiative originated and developed in the UK. The account was reviewed by all participants for accuracy and completeness.
Results: A cohesive account about the development of the PPC initiative provides insight into the original motivations and concepts underlying its history. The historical trajectory highlights key comparisons between service approaches to birth and death. Furthermore, it provides insight into the process by which PPC arrived at its place in national policy.
Conclusion: The originators' account provides a basis for understanding the significance of how PPC has developed to its present day format and its utilisation within end of life care policies in the UK. This information about the origins of the PPC initiative offers policy makers and clinicians a basis for understanding the initiative, relating it to patient care and envisioning its potential for improving people's experience of palliative and end of life care.

PE 2.S371

Contribution of low- and middle-income countries (LMIC) to palliative care research

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Aims: Important aspects of the palliative care needs of patients from low- and middle-income countries (LMIC) are largely unexplored. About 44m of the 56m annual deaths worldwide occur in developing countries and more than 33m of those concerned would benefit from palliative care. In this context, the understanding of specific social and cultural needs is fundamental to the development of appropriate health policy and clinical practice concerning palliative and end of life care. This study aims to answer the question: what are the contributions of LMIC to the published palliative care literature?
Methods: A bibliometric analysis was conducted in Medline and EMBASE (to June 2008). Articles were included when either the first author (institutional affiliation or contact address) or the data collection were derived from LMIC, as defined by criteria of the World Bank. Excluded were editorials, letters and articles done in migrant and non- palliative care populations.
Results: The literature research resulted in 845 references. In total 245 articles coming from LMIC were identified, being published by 34 LIMC (27.3% of LMIC). The first publications appeared in 1982. The study shows a rather modest contribution of publications from LMIC. However, the volume of publications within LMIC is distributed unequally: Upper-Middle-Income Countries (UMIC) published almost half of the articles (46.9%) while only 11% of the publication came from countries with low-income countries (LIC). In contrast, 104 LMIC (72.7% of LMIC) do not have any registered publications. Surprisingly, 25% of the articles with data from LMIC have been published in High Income Countries (HIC). Reasons for the underrepresentation, as well a possible correction of this imbalance are discussed.
Conclusions: Palliative care research should be a priority in LMIC, where many patients could benefit tremendously from it, and publication of findings in these countries should be encouraged.

PE 2.S372

Linking legal advocates and palliative care providers in South Africa

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In South Africa in most cases, the task of handling all "non-medical" aspects of patients' lives falls on a social worker who is neither legally trained nor empowered to provide legal advice or referrals. Partnerships between legal advocates and hospice and palliative care providers are thus an effective way to enhance the effectiveness of both sets of professionals, and ultimately to improve the quality of life of their clients and patients.
In South Africa, a reference committee of palliative care and legal service providers is carrying forward an initiative to integrate legal and human rights advocacy and services into hospices and palliative care programs. In a country where 5 500 000 people are infected with HIV -almost 14 - 6 000 000% of the population, this comprehensive package of services is crucial for addressing both acute physical needs and the social dimensions of the epidemic.
The reference committee is composed of three working groups focusing on the need for materials straddling both the palliative care and legal disciplines, the integration of legal services in hospices, and advocacy for improving access to palliative care in the public sector as a basic human right.
People living with HIV and AIDS often face complicated legal questions related to the disposition of property, planning for children, accessing social benefits, and combating discrimination in employment, housing, and education. Children, elderly caregivers, and child and youth-headed households are particularly vulnerable to human and legal rights abuse. This initiative aims to create the partnerships necessary between the palliative care and legal communities for the provision of comprehensive services that enable both pain management and the tackling of important social concerns.

PE 2.S373

Evaluating the views of decision makers and lobby groups towards measurements for better palliative care in Germany

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Aims: The German health care system is shaped by numerous lobby groups, organizations and institutions. It is important to consider their views for the decision and policy making process in order to further develop palliative care. Therefore, we have carried out Germany's first representative evaluation that assesses a wide range of stakeholders acting at the health system's meso and macro level with regard to their respective views on palliative care.
Methods: 442 organizations and institutions (national or federal state level) were included and grouped: patient and nursing organizations, medical associations, specialised palliative care organizations, political institutions and cost units. Using a pre-tested standardised questionnaire, the participants were confronted with 18 selected improvement measurements based on technical literature. They were asked to assess the measures with regard to their general relevance and their transferability to the German health care system (2-point-likert-scale: 1=rather good, 2=rather bad).
Results: The response rate was 67%. In most cases (13/18) the general relevance of the measures was evaluated as rather good (mean<1.5) whereas their feasibility in Germany was evaluated as rather bad (mean>1.5). For the paid absence from work for people who care for their relatives, for example, the general relevance was assessed 1.3 while the feasibility was assessed 1.9 ($p<0.001$). Only 4 measures were evaluated as rather good with regard to both general relevance and feasibility. An example is the obligatory education in palliative care for professional caregivers.
Conclusion: There are significant barriers to overcome in order to improve palliative care in Germany. Possibly, the feasibility of essentially auspicious measures is seen as difficult because of the fragmentation of responsibilities and partly conflictive interests of lobby groups.
Funding: The study is funded by the German Research Foundation (DFG).

PE 2.S374

Developing an all-Ireland Institute for Hospice and Palliative Care: Progress to date

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Background: There are growing calls for a more integrated approach to the development of policy, practice, education and research in palliative care and in particular at the level of national jurisdictions. One response to this is the creation of mandated Institutes to co-ordinate and promote activity.
Aim: The creation of an all-Ireland Institute for Hospice and Palliative Care with the following vision: to improve the experience and understanding of palliative and end-of-life care on the island of Ireland, by enhancing the capacity to develop knowledge, promote learning, influence policy and shape practice.
Methods: Two externally facilitated open workshops were held in Spring 2007 to explore initial options and concepts. A multi-disciplinary, inter-sectoral and cross-jurisdictional steering group was established in Autumn 2007 to create a Business Case. In Spring 2008 a fund-raising strategy got underway.
Results: The proposal is to create a dynamic initiative, of limited lifespan, which will promote a step change in the provision of end of life care on the island of Ireland. It will undertake work in three main areas:
1) education and training
2) research and the creation of new knowledge
3) serving as a resource to service providers and policy makers.
Philanthropic and state funders have shown considerable interest in supporting the proposed all-Ireland Institute and by Autumn 2008 'pledges' of Euros c7 million had been obtained against a proposed five year budget of Euros c12million.
Conclusions: A public tendering process to select a consortium of organisations to operationalise the vision for the Institute is planned for 2009.

PE 2.S375

World Hospice and Palliative Care Day - Discovering your voice

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The aim of this session is to review the achievements and challenges of World Hospice and Palliative Care Day against its stated objectives as well as considering how the potential of the Day can be maximised in the future - internationally, nationally and locally.
World Hospice and Palliative Care Day is a unified day of action to support and celebrate hospice and palliative care around the world. The Day is supported by hospice and palliative care organisations from all over the world. The stated objectives of the Day are:
• To share our vision to increase the availability of hospice and palliative care throughout the world by creating opportunities to speak out about the issues.
• To raise awareness and understanding of the needs - medical, social, practical, spiritual - of people living with a life limiting illness and their families.
• To raise funds to support and develop hospice and palliative care services around the world.
Data has been gathered from evaluations of World Hospice and Palliative Care Day from 2005-2008 in addition to semi structured interviews with key individuals from organisations and individuals around the world that have participated in World Hospice and Palliative Care Day.
World Hospice and Palliative Care Day is a key opportunity to provide a global voice on the often neglected issue of hospice and palliative care. It provides an opportunity for individuals and organisations worldwide, that may sometimes be isolated in their own settings, to join with others to raise awareness and funds and to share our vision of making hospice and palliative care available to all.
This session will consider how individuals and organisations have used World Hospice and Palliative Care day to achieve their objectives for the development of hospice and palliative care and how this can be maximised into the future.

PE 2.S376

MDS (minimum data set): A national project of palliative CH (Swiss Association for Palliative Care)

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Objectives: Palliative ch aimed to develop a MDS in order to identify the profile of palliative care patients. Twenty years after the development of palliative care in Switzerland, there is still no national data available, due to the fact that the existing statistics do not codify palliative care.
MDS meets the query's of our public health administrators, provides information to funders (state and health insurers) and contributes to benchmarking between the various structures.
Project: Since Sept. 2006, MDS was developed by a specific working group composed of nurses, doctors and a manager, representing the various linguistic regions of Switzerland.
In a first step MDS has been designed for specialized palliative care services like hospices, pc hospital units, as well as for mobile teams (intra-and extra-hospital). MDS collects the following data:

Profile of patients	Age, sex, diagnosis, place of residence
Symptoms Assessment Tools	ESAS, MMS
Continuity of care and patient transferrring	Delay before pc accessibility, delay before leaving hospital, reasons for transferring from one health structure to another one
Death	Date and place of death, patient's wishes

Results: From 01.07.08 to 30.09.08, 22 palliative care teams have completed the MDS for all their patients. These teams represent all types of palliative care as well as the three linguistic regions of Switzerland. The

results of the test phase will be available by early December 2008.
Conclusion: The Swiss health system is organized at regional level (26 cantons) and covers three linguistic regions. Therefore it was hard to develop data taking in account the regional and linguistic diversity.
As MDS was an palliative ch initiative, participation in the survey was voluntary. Nevertheless, 22 teams out of 38 participated, which represents a rate of 63%.

PE 2.S377

The challenges of palliative care faced in Lithuania

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Lithuania is a country which has lost its tradition to look to death as a natural process, tradition to die at home, tradition of volunteering. So it was very difficult to establish palliative care services in our country when we gained our independence in 1990. The first steps of PC in Lithuania were based by enthusiasm of single persons:
- Kaunas Nursing Hospital was established by initiative charitable organization Caritas in 1993; one of its tasks was to offer PC services;
- subdivision of Pain and Palliative therapy was organized in Vilnius Oncology Institute in 1995;
- Lithuanian Palliative Medicine Association was founded in 1995;
- Charitable Organization Caritas fulfilled project "Home Palliative Care" in 2001;
- Palliative Care service was organized in the Center of integrated Services in city Panevezys in 2003.
The Palliative Care education for nursing and medicine students started in Kaunas University of Medicine.
The first strategic document regulating Palliative Care in Lithuania was the program of the Prophylaxis and Control of Cancer (2003); it was mentioned that palliative treatment and care of oncology patients can be offered in oncological institutions and nursing hospitals.
Other documents of Health Ministry of Lithuania regulated prescription of drugs (2005-2006).
Palliative Care was legalized on January 11th, 2007 as separate service for adults and children by the Health Ministry of Lithuania.
Accreditation of Palliative Care services was confirmed on February 14th, 2007. Basic costs of different forms for PC services (inpatient, outpatient, day care, home care, mobile team) were set for adults and children in May 16th, 2008.
Conclusion: In these days we have the time for creation of contemporary Palliative Care in Lithuania. God bless us.

PE 2.S378

Implementation of palliative care (PC) as a state programme (SP) in Latvia

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Aim: Analysis of the situation of PC in Latvia, stating priorities to develop SP, implementing PC as a system in the country from 2008 to 2015.
Study design: In January, 2008 Ministry of Health (MH) realized necessity of PC in Latvia. MH designed it as a SP. Policy consisted of several steps:
1) establish a group of 8-10 experts: PC specialists, health policy makers, financial experts
2) analyze situation, statistics, problems in Latvia both in oncology and non-oncological diseases.
From 60000 oncological patients (pts) 10000 have a need for active PC. In 2007 PC received 2411 pts. About 20000 - 25000 pts with non-oncological diseases: HIV/AIDS, neurological, resistant tbc, heart, renal, hepatic failure pts needed PC which is not available yet. There are 113 specialized PC in-patient beds in Latvia mostly for oncological pts, but need is for 125-130 beds. Day care centres, mobile teams, home care should be organized. SP includes development of the children PC. Only 1 outpatient PC children team is in Latvia. Served 207 children in 2007. 10 in-patient beds needed
3) define PC as a subspecialty, multi-, interdisciplinary approach
4) stated main goals of the SP: access to PC, quality of life. Subtasks - develop PC structures, evidence-based PC, implement specialized knowledge: 6 different accredited educational programms
5) human resources: in 2010 is a need for 181 educated specialists in PC (doctors, nurses, social workers etc). Time schedule is worked out for each year
6) state results (access to PC, number of pts) each year + 5% for adults
7) responsible institutions: MH, Ministry of Welfare, local governments, PC, societies
8) stated finances, resources (existing and necessary).
Results: Analysis revealed that PC as a system does not exist in Latvia. SP outlines main directions until 2015: PC as a priority, organize human resources, PC structures, education.
Conclusion: SP for PC in Latvia is designed according to local situation, EU and WHO standards.

PE 2.S379

"Palliativguiden" - The Swedish palliative care directory 2008

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Aim: To create an easily accessible web based and printed guide to specialised palliative care in Sweden.
Background: The provision of specialised palliative care in Sweden, 9 million inhabitants and a population density from 0.24 - 4 200 inhab/km2, has developed in spite of a national strategy. There is an obvious difference in palliative care provision in different parts of the country.
Methods: All known palliative care services in Sweden were contacted through available networks. Based on a description of specialised palliative care; units and teams were encouraged to register specific data and a general description of the service into the web based directory on line. Before registration a contact person had to be assigned a password and before publishing the head of service was automatically informed. The information should be continuously updated by the service providers. A printed version of the register was released in June 2008 proceeded invitation letters to update the online version and to proof read the slightly edited description of the service etc. "Palliativguiden" has been sent to health care providers, decision makers, politicians and the media to increase knowledge about palliative care and to be used as base for further development.
Results: There are 82 in-patient services and 72 home care services available in Sweden. The data has been validated by assigned palliative care specialists, a nurse and a physician, in each county.
Discussion: The online version of "Palliativguiden" is publicly available and therefore a resource in searching for a palliative care service. It is a potential problem that the services in the guide do not understand the need to keep the online register updated. There is also a not fully understood demand to describe the services in an informative and clear way. "Palliativguiden" has already been used to locally start a debate on the need for further development of specialised palliative care.

PE 2.S380

The new legislative-normative basis for development of the palliative care in Georgia

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Pain is the one of the most problematic issues in chronic incurable patients. Today, the opioids are recognized as scientifically confirmed and necessary pain-relief medications in patients with advanced cancer, cardio-vascular, neurological diseases, AIDS, etc. Taking into the account the legal restrictions for opioid circulation in many countries, resulted in ethical and juridical nonsense, European Committee give the recommendations to the governments to access and improve the legislation for providing of the quality PC and pain relief. Critical reconsideration of legislative-normative basis of PC was started in Georgia in 2006. Office of Coordinator of PC National Program (OCPCNP) together with the Ministries of Labor, Health and Social Affairs (MoLHSA), the Ministry of Internal Affairs (MIA) and Parliament Committee for Healthcare and Social Issues, under the patronage of First Lady of Georgia created the draft of amendments in 4 Laws of Georgia which were approved by Parliament of Georgia in April 08, 2007.
Correspondingly:
- Definition of PC was added to National legislation;
- PC was recognized as absolutely necessary component in system of medical aid;
- Pain relief in the end-of-life patients was recognized as completely necessary issue;
- Government was engaged to provide patients by necessary amount and necessary forms of opioids, according to the international standards;
- The Ministry of Health was obligated to create and sign "The Instruction of PC for chronic incurable patients".
As a result of these amendments, MoLHSA and MIA in cooperation with the OCPCNP and WHO and OSI International experts prepared normative orders, which were signed in July 2008.
These orders provide the modern instruction for PC as well as the prove administration and prescription of opioids harmonized with the international standards.

PE 2.S381

Role of the social movements in the development of palliative medicine in Russia

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Development of palliative medicine in Russia was started about 20 years ago as pain therapy offices. Now there are more than 200 palliative care units, including territorial centers, palliative care departments, hospices, pain therapy offices and mobile patronage groups. Despite some progresses development of the palliative care meets some barriers. One of them is lack of knowledge about palliative care both among medicine professionals, and among population as a whole. We believe that activity of the social movements could help overcome this barrier. The All-Russian social movement "Medicine for quality of life" was created more 5 years ago and was aimed to facilitate consolidation between medicine professionals and a civil society. Since 2006 all-Russian forum "Medicine for quality of life" has started. The forum takes place in capitals of all of 7 federal districts of Russian Federation (Moscow, St. - Petersburg, Nizhniy Novgorod, Rostov-na-Donu, Yekaterinburg, Novosibirsk, and Khabarovsk). By this time more than 8 thousand delegates from 67 regions of Russia took part in the forum. Not only medicine professionals, but representatives of the executive and legislative power, and activists of some political parties took active part in the work of the forum. The program of the forum includes palliative care conference, seminars and round tables. We hope that social movements will promote the further development of the palliative care in Russia.

PE 2.S382

Palliative medicine in Germany - Four years' update

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Background: In 2008, 7 European countries (Belgium, France, Germany, Great Britain, Poland, Spain and The Netherlands) each made a national inventory of the state-of-art in palliative care (PC) in the framework of the EU-funded project Best Practice in PC. In 2004, a study on the state-of-art in PC in 11 European countries was conducted in order to explore which achievements are recommendable for further governmental commitment in the development of PC in Germany. The collected information is used to give a four years' update on the development in Germany.
Methods: Review of literature and policy documents including grey literature on a regular basis during the course of the data collection, development of a questionnaire and glossary (2004 by a national, 2008 an international focus group), interviews with national experts.
Results: Services: Increase in palliative care units 52% (106/162) /beds 51% (823/1,240); inpatient hospices 14% (129/147)/ beds 14% (1211/1382); establishment of new kind of specialised PC home care service.
Education: Establishment of a new sub-specialty in palliative medicine (by 7/08 1,500 specialised physicians); increase in number of chairs by 50% (2008: 4, with 4 more to be appointed soon) and of medical schools with mandatory PC tuition; integration of PC in the education of physiotherapists.

Law: New law entitling patients to specialised outpatient PC, regulation of remuneration contracts with statutory health insurers (SHI); budget: ¤ Mill 630 from 2007-2010. Volunteers: Now represented within the German Association for Palliative Medicine.
Research: For the first time ever public funding (Deutsche Forschungsgemeinschaft); research network of 4 universities with chairs in PC.
Conclusions: Within only 4 years, the state of art in PC and its recognition by the government, SHI and public funders progressed considerably. Research in the quality of PC practice is needed and will be conducted in the framework of the EU project.

PE 2.S383

Palliative cancer care: Developing subspecialty of both palliative care and of oncology

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Aim: Due to successes of multidisciplinary anti-cancer treatment more people are living longer with advanced, incurable cancer, typically challenged with various phases of cancer control, recurrences and finally death. Throughout the course of illness patients experience a fluctuating myriad of - for cancer diseases typical - symptoms, distress, and complications of cancer and/or adverse effects of treatments. To describe oncology societies efforts to develop and integrate palliative cancer care (PCC).
Methods: Description of key elements of past and recent ESMO & ASCO PC initiatives, including policy, education, service development, research, and conferences. Comparison of findings with EAPC's efforts and leadership on providing norms and standards of PC.
Results: ESMO and ASCO PC committees published (2003 / 1998, 2008) organization-leadership approved and peer-reviewed policy statements. Developing education programs and associated service models provide knowledge about
A) key PC values & principles (e.g., dignity, autonomy, communication [disclosure, existential themes], quality-of-life & priorities directed problem-based decision-seeking, advanced directive processes, multidimensional assessment, end-of-life & bereavement care, patient & family empowerment, continuous coordination of services, multi-professional approaches), and
B) cancer-specific PC issues (cancer symptoms & complications, alleviation or prevention of side-effects of anticancer interventions and their use to improve symptom control in the context of state-of-the-art symptom control).
A **key challenge** is the need for both cancer-specific and PC specialists' competencies, requiring competency-based shared-care (1°, 2°, 3° PC). Quality improvement and awards (e.g., ESMO designated centers) initiatives support the process of integration.
Conclusion: ESMO and ASCO take active steps towards development of PCC, its important that PC physicians are aware of and contribute to these initiatives.

PE 2.S384

Transfer of the Kerala Neighbourhood Network in Palliative Care (KNNPC) to Switzerland: Mission impossible?

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Question: The Kerala Project NNPC is basically run by volunteers, and professionals in Palliative Care provide interventions only if called by the network. In three different settings in Eastern Switzerland/ Liechtenstein (urban, rural, mixed) an explorative study showed a variety of different services that offer support at home for severely ill patients and their families, but a lack of collaboration and coordination among these services have been stated. In addition, volunteer support is rarely integrated in home care.
Methods: potential barriers for collaboration and exchange and integration of volunteers were analysed during semistructured interviews as well as through the "world cafe- method" during regional round tables calling together the different support organisations.
Results: There were several barriers detected which may not exist in Kerala but in Eastern Switzerland:
(a) Death and dying occurs in the homecare setting in less than 20% and experience of caring for the dying is lacking,
(b) the population expects professional health care at the end of life, and volunteers may not be accepted as being helpful,
(c) among different support organisations competition and a lack knowledge of each others competences undermine effective coordination and collaboration,
(d) the majority of volunteers self limit their activities to bedside care only,
(e) there is no commonly accessable documeantation system,
(f) there no coordinating person (volunteer or professional).
Conclusions: A highly professionalised health care system, low rates of home deaths and deficits in communication and collaboration among regional support teams are major barriers for effective community Palliative Care compared to Kerala. Over-medicalisation of the end of life is often criticized in our country but the delivery of "humanistic" care and support through non-professionals/ volunteers seem to be rarely accepted and has no tradition in our country.

PE 2.S385

Do patients in palliative care receive informations about advance directives?

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Research aims: Since 1996, the Geneva legislative frame makes a large place to advance directives (ADs). At each admission, the availability of completed ADs is to be checked and patients should receive information about ADs. The aim of our study was to measure the number of patients with an advanced oncological disease who had completed ADs before admission, those who were interested to receive the information and those who completed ADs during hospitalisation.
Methods: Retrospective chart review of patients with an advanced oncological disease admitted from August 2007 to July 2008 to the Division of Palliative Medicine of the University Hospitals of Geneva.
Results: 365 patients were hospitalized during this period. For 232 patients, no informations about ADs were available in their chart. 133 were thus analyzed (mean age 75.5±12.9). 15 (11%) had signed ADs at admission of which 9 were completed during a previous hospitalization. 19 patients received complete information, but further process stopped because of the onset of delirium or worsening condition in 8, and simple oral transmission of wishes and values in 11 with, five of them designating a surrogate. Twenty-one (17%) patients completed and signed ADs during hospitalization. There were significantly younger than patients not completing ADs (mean age 67.9±14.3, P=0.013). Main items were indications for attempt at resuscitation, introduction of artificial nutrition and hydration, palliative sedation and autopsy.
Conclusion: Written informations about ADs are still not developed at a satisfying level in the patient's charts. Completion of ADs concerns a minority of relatively young patients. Patients with advanced disease should know more about ADs and should be encouraged to complete them early in the course of an incurable disease.

PE 2.S386

Georgian Orthodox traditions and spiritual help for cancer patients

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Description: The first Church care center (hystorical name Ksenon) of incurable s was biult by the King David Agmashenebeli in 1106-1110 years. During the Soviet era before 1990 patients have been treated Georgia without religiou support. Nowadays more and more people approach to the church and revival of the old religious Orthodox traditions is obvious in the Country. The role of spiritual support is growing day by day. This gives incentive to incurable patients for future of their lives. In the first Palliative Care Clinic wich was established in Tbilisi (2005 year/Georgia), before today (1.10.2008) have registered 1138 patient and from them 908 (79,8%) was Orthodox.
Objectives: Death itself and death of cancer patients provoke very bad feeling in patients and their family members as well as caregivers, therefore the main purpose of the spiritual care is to help medical personal to assist patients. The church tradicions and praies prepare patients and surrounders for death and gives them belive for the new life. There are studies in Georgian that present the Georgian Orthodox rituals surrounding terminal condition. The studies present diseases and death as well: rituals before a person's death; preparation for a funeral; funeral and postfuneral period, services in a Church - blessings of the cross at a grave and burial of the body. The knowledge of these traditions is of vital importance for patients during both the disease course and dying process, and it is also important for caregivers.
Conclusion: At the moment, strong cooperation between medical practice, community and religion is needed to make progress in palliative care and provide quality of life for patients with terminal conditions. Palliative care for patients and their families must contain by all means a religious component. Spiritual correction is of crutial importance that was proved by our study.

PE 2.S387

Preferences of advanced lung cancer patients for patient-centered information and decision-making. A prospective multicentre study in 13 hospitals in Belgium

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Aims: To identify the preferences of advanced lung cancer patients for information and decision-making participation in treatment options, healthcare-setting transfers and end-of-life decision-making.
Methods: Over the course of one year, pulmonologists and oncologists in 13 hospitals in Flanders, Belgium, invited patients with an initial diagnosis of non-small-cell lung cancer IIIb or IV to participate in the study. Shortly after inclusion, the patients were interviewed with a structured questionnaire, and subsequently every three months, until death, a follow-up interview was organised.
Results: 128 patients with a median estimated survival time of 10 months were eligible and participated. Almost all wanted information on diagnosis, treatment and cure rate and slightly fewer on life expectancy (88%). Sixty-three percent of patients preferred to be informed about palliative options and 57% about end-of-life options. In treatment decision-making, 63% of patients preferred the doctor to make decisions. In end-of-life decisions, 84% of patients preferred to be involved in decision-making.
Conclusions: A patient-centered approach to decision-making participation in advanced lung cancer patients implies full information for most patients, as well as participation in end-of-life decision-making. The complex pattern of preferences of an advanced lung cancer patient should be thoroughly explored by the treating physician, and separately with regard to different types of decision making (treatment options, healthcare-setting transfers and end-of-life decision-making).

PE 2.S388

The effect of recording consultations involving the transition to palliative care on quality of life of patients with upper GI or ENT cancer; A pilot study

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Objective: The provision of recordings of key consultations may benefit adults with cancer, although there is hardly any evidence on the potential value of tapes in the later stages of cancer care. In this pilot-study, we studied the feasibility and desirability of palliative bad news consultation tapes to patients with cancer.
Methods: Twenty-one patients with irresectable or recurrent esophageal or head or neck cancer were randomised to receive a CD of their bad news consultation (n=11) or not (n=10). Data on quality of life (EORTC QLQ-C15 PAL, Hospital Anxiety and Depression scale, loss of control scale, Patient Information Need Questionnaire) and openness to discuss cancer (Openness to Discuss Cancer in the Family scale) were collected at randomisation and 1 week and 1 month afterwards. In addition, all problems concerning the

procedure were documented.
Results: We experienced little procedural problems, although it was difficult to mark the initial palliative consultation. Data of 4 patients could not be used, as these patients refused follow-up. These patients were more distressed at baseline than compliant patients. All 10 distributed CD's were listened to, 8 by patients and 10 by their relatives or general practitioner. Three quarter of the patients found the availability of the CD to be of moderate or high importance. Patients in the CD group showed a higher deterioration on 11/17 and 13/17 aspects of quality of life at 1 week and 1 month, respectively, than patients, who did not receive a CD. Openness to discuss cancer in the family was improved at 1 month in the CD group, but not in the group without CD.
Conclusion: The recording of a consultation is well perceived by patients with a poor prognosis and their relatives. Based on our results, a large randomised study investigating a consultation CD in these patients is feasible and desirable, in order to confirm or to exclude the initial, partly negative results.

PE 2.S389

An observational study of alcohol-related problems in patients with advanced cancer

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Aim: To look at all alcohol related problems i.e. "hazardous drinking" / "harmful use", and "alcohol dependence" in a cohort of palliative care patients at a UK oncology centre.
Methods: This was an observational study conducted at the Royal Marsden Hospital (Surrey). Patients were asked to complete the Alcohol Use Disorders Identification Test (AUDIT: a validated tool that assesses "hazardous drinking" / "harmful use" and "alcohol dependence") [WHO 2001], Hospital Anxiety and Depression Scale (HADS) and the Memorial Symptom Assessment Scale Short Form (MSAS-SF: a validated tool that assesses the presence/distress caused by physical and psychological symptoms).
Results: 120 patients completed the study. The mean age was 61 years, there were 65 (54%) women, and the range of cancer diagnoses was representative of referrals to the palliative care service. 18% of patients met the criteria for alcohol use disorder, and 6% met the criteria for "alcohol dependence". There was a correlation between the AUDIT score and gender (males > females: P = 0.012), cancer diagnosis (positive correlation with head and neck cancer: P = 0.002), and smoking (positive correlation with current smoking habit: P < 0.001). There was no association between AUDIT score and anxiety (P = 0.612), depression (P = 0.085) and presence of distressing physical symptoms (P = 0.908).
Conclusions: The prevalence of alcohol use disorders in this cohort of patients with advanced cancer is less that that reported in the general population in the UK (i.e. 26%) [DOH, 2005]. However, the prevalence of alcohol dependence perse in this cohort of patients was similar to that reported in the general population in the UK [DOH, 2005]. Interestingly, it would appear that the physical and psychological burden associated with cancer does not lead to increased incidence of alcohol misuse in our population.

PE 2.S390

´The art of end of life care´ - How the creative arts can communicate and deliver an effective end-of-life care service

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Expression, psychological exploration and ritual have always been central to the delivery of an effective and complete palliative care service. However, it is only more recently that the creative arts have begun to be proved as a dynamic force when offfered as an opportunity for those who are dying to tell their story and leave a legacy behind when they die.
This presentation will focus on the responsibility of end-of-life care institutions to provide a broad and varied range of services in order to address the ´total pain´ that they claim to deliver (Saunders 1973). A range of dynamic and moving examples will be used in oder to prove the efficacy of such work when used as part of a patient´s total care package at the end of life, including a range of DVD´s and tape recordings created by patients as well as other artworks such as paintings, poetry and music. Examples of new research carried out by a large award-winning Arts Team at St. Christopher´s Hospice, London will be presented for consideration (Hartley N. & Payne M. 2008). Case studies from the recently published book ´The Creative Arts in Palliative Care´ editied by Nigel Hartley will also be used as part of the presentation.
The arts cannot work in isolation. The results of a qualitative evaluation study asking members of a large multi-professional team to comment on their perceived view of the effectiveness of such work when used as a planned part of patient´s care will also be shared. Through the sharing of the artwork, case studies and evaluation study results, the true efficacy of, and depth of meaning acheived by, using the creative arts as a central part of multi-professional working will be valued and understood.

PE 2.S391

Dying to talk - Engaging the public in advance care planning

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Aim: Hospice care helps patients and families talk about difficult subjects. Advance care planning is key to UK end of life policy. Hospices publicly engage through fund raising but this discourse rarely tackles "death" directly. An open meeting was designed to engage the well public in the concept of advance care planning.
Method: Hospice clinicians, education, fund raising and PR brain stormed the theme and meeting design. Design included visual triggers (communication quotes and images); audience generated questions, a user, public figure and hospice consultant speaker. 85 participants attended the meeting including 20 staff members and volunteers.
Results: Discussion within the team to provide a forum to discuss the theme and concern about potential emotional harm to those attending. Dissonance between what people expected to hear (the hospice) and the meetings theme (advance care planning).Challenges of using an eloquent user praising the Hospice instead of the meetings' theme. Audience generated questions were specific about the hospice (referrals and catchments areas).Attendance from known hospice supporters. Difficulty in engaging the audience on this subject in this forum. Multi professional collaboration enabled a wide conceptual framework.
Conclusions: It is difficult to talk about mortality. The theme was provocative, the audience questions were not. Feedback was positive. It is unclear whether we met our objectives. Terror Management Theory suggests that mentioning the word "death" raises anxiety. People react differently compared to a situation where death hasn't been mentioned. Anxiety reducing strategies should underpin the forum. The meeting was comfortable but formal possibly not the right structure for the meetings theme. Perhaps talking about the Hospice and fundraising is as close as many will come to thinking about mortality. The meeting influences our public engagement strategy and demonstrated the benefits of multi disciplinary working.

PE 2.S392

Anxiety and prevalence of psychiatric disorders among patients waiting for surgery with suspicion of ovarian cancer

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Aims: The goal of the current study was to determine the anxiety level and prevalence of psychiatric disorders among patients waiting for surgery of ovarian tumors. Also analyzed were the predictive factors for psychiatric disorders and changes after surgical diagnosis.
Methods: Patients who underwent surgery for ovarian tumors were examined before and after surgery with the Mini International Neuropsychiatric Interview, the Spielberger State-Trait Anxiety Inventory (STAI) and the Mausley Personality Inventory (MPI). Participants diagnosed with cancer were examined a third time after an explanation about the necessity of adjuvant chemotherapy or not.
Results: Thirty-seven of the 74 appropriate cases were informed of this study, and all except one patient consented to participate between June 2005 and February 2007. Twenty-seven participants completed the study and were analyzed. Nine (33.3%) of these 27 participants were diagnosed as having adjustment disorder. There were no differences in demographic data, STAI trait anxiety score and MPI score between the participants with or without adjustment disorder. At the pre-surgical interview, the STAI state anxiety score of the participants was high (49.5±10.30). After pathological examination of the tumors, it was found that 12 patients had cancer (Malignant group) and 15 patients had a benign tumor (Benign group). At pre-surgery, the prevalence of adjustment disorder and the level of anxiety in the Benign group were similar to those in the Malignant group. There was a second surge of anxiety in patients who needed chemotherapy.
Conclusion: These findings demonstrate that patients with suspected ovarian cancer experience a high level of anxiety. Physicians should be aware of the risk of adjustment disorder in these patients. Additionally, ovarian cancer patients need psychological assessment during the course of treatment.

PE 2.S393

A longitudinal study comparing two different periods of evolution of an oncological home-care team for advanced and far advanced cancer patients

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Background: In health-related organizations, the amount of stress felt by professionals is generally higher than in other categories and could bear dramatic consequences for working efficiency and individual and team wellness.
Purpose: The purpose was to compare the assessment of well being perceived by the oncological home care team in two different periods.
Methods: At first, the well-being of the operators was studied in 2 dimensions: individual and organizational. Secondly, 3 years after, measurements were repeated in order to compare data. The sample consisted of 115 operators, 80 physicians and 35 nurses. The study has been developed by the ANT Italia Foundation, at 11 ANT oncological hospital at home (ANT-OHH) in Italy. Data were analysed using ANOVA for out-group comparison and Spearman's ranks correlation.
Results: Both first and second results showed a medium-low level of burnout in the comprehensive ANT team. In our data, Emotional Exhaustion and De-personalization of ANT operators were significantly lower compared to normative data. In our sample, organizational climate was generally better than in the Italian normative sample at all levels. However, in the first study the two bigger teams of sample considered work with a less cooperative behaviour then the other teams. Moreover, the operators of these teams felt less involved and safe in decision-making process and in information circulation; finally, they perceived less support of innovation and they described an interaction frequency inferior to normative data. These data changed with the follow-up, proving an operator's higher work satisfaction in all dimensions. It may be supposed that these positive results are connected with the modifications in the organization of work teams that ANT has worked out in the last years, such as the work team in mini-ward reorganization and the construction of a multidisciplinary, more efficient and functional new medical institute.

PE 2.S394

Burnout syndrome in palliative care units

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The burnout was first described by Freudenberger, in 1974, as a phenomenon characterized by a "(...) state of fatigue or frustration caused by the consecration to a cause, a way of life or a relationship that did not match expectations "(Delbrouck, M., 2006:15). This implies a strong sense of lost identity, in which the person puts herself into question, feeling empty. Often, burnout is seen as a result of great personal involvement, motivation and commitment. It can be defined in its multidimensionality: emotional exhaustion,

depersonalization, lack of personal and professional completion. The provision of palliative care can lead health care provider's to physical, psychological and emotional exhaustion, which may develop to burnout. From the surveys in this area, it is evident the absence of specific studies on this syndrome, either in Portugal or abroad. It is therefore essential to understand this phenomenon, particularly at the level of burnout professionals working in the field of palliative care present.
Aims:
(i) To understand the burnout syndrome in physicians and nurses in the area of palliative care in Portugal,
(ii) To identify the levels of burnout of Portuguese palliative care physicians and nurses and
(iii) To identify the risk factors for the development of burnout in the Portuguese palliative care physicians and nurses.
Methods:
(i) Application of self-fulfilment questionnaire - Maslach Burnout Inventory -General Survey,
(ii) Observation of the work contexts - Portuguese palliative care units/teams,
(iii) Interviews conduction with Portuguese physicians and nurses who pursue their activities in palliative care.
The results underline the importance of promoting the prevention of burnout at palliative care. The development of the burnout syndrome in physicians and nurses in palliative care has serious consequences, both for themselves, or the consequences that entails for patients and their families.

PE 2.S395

Sexuality and intimacy for palliative care patients

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Background: Studies show differences in the understanding of sexuality between palliative care patients and health care professionals. Patients consider sexuality as important for their quality of life, even at the end of life. Studies also point to a discrepancy between the need of patients to talk about sexuality and a lack of attention in palliative care.
Goals: The study aims to gain insight into how palliative care patients experience sexuality. Specific goals are to learn how patients define and experience sexuality, how this evolved during the illness, and how palliative care can meet the needs of patients.
Methods: The patients of two palliative care units (Montreal, Canada and Munich, Germany) were asked to take part in the study. The single meeting interview comprises demographic data and a semi-structured interview, recorded on audio tape for verbatim transcription. Both study sites make use of additional questionnaires.
Results: At the moment, 22 of 40 asked to participate agreed (Munich: 14/33, Montreal 6/7). Patients' ages range from 33 - 86 years, 12/22 are female, most are married or in partnership.
Definitions and meaning of sexuality typically focus on being close, some explicitly include intercourse and sexual functioning. Patients report changes in the experience of sexuality, sometimes changing to intimacy. Data show a significant decrease in sexual activity (p=0.01) and interest (p=0.01). Most patients report stability or improvement with partnership and sexual relationship. Participants explicitly wished to be treated as a whole person; most wished for privacy when in an in-house clinic.
Conclusion: All palliative care patients reported changes in the understanding and experience of sexuality while the importance for their quality of life remained stable. Functional aspects decreased while being close and experiencing intimacy increased in importance. Participants wish for respect and privacy when in health care institutions.

PE 2.S396

Truth telling in palliative paediatric care: The adolescent's perspective

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Background: There is often uncertainty as to what is in a dying child´s best interests and conflicts arise when the family and practitioners hold different perspectives (Breen, Abernathy, Abbott & Tulsky 2001). A further challenge of paediatric palliative care is the child's continually changing physical, emotional and cognitive development and how such impacts on understanding of their condition (Watterson & Hain 2003).
Methods: Semi-structured interviews were conducted with three adolescents (2 = non cancer condition, 1 = cancer condition) and their parents. The aim of each interview was to explore the participant's lived experiences of life-limiting illness.
Findings: An interesting theme that arose pertained to truth telling and the communication of prognosis between parent and adolescent and adolescent and professional. Interestingly, each adolescent was aware of their prognosis despite this not being discussed with parents or in any great depth with professionals. The adolescent's each talked about wanting to discuss terminal phase, funeral and 'being remembered' plans with key professionals - so as to not worry or upset their parents. Conversely, parents talked of instilling hope and ambition in their children and did not want to focus on their child's prognosis in any direct discussion with their child - although they were aware that such a conversation may soon be looming.
Conclusions: This study demonstrates that palliative care is moving forward as children are establishing good relationships with their health care providers and want to engage in very difficult illness related conversations with them. Alliances can be made between professionals and adolescents - but efforts are needed for this to happen. In this study, key professionals were relied upon for honest and open discussion and it was perceived a necessity for such to protect and aid parents and to ease the worry of the adolescent's themselves.

PE 2.S398

Hope and quality of life in patients with advanced cancer

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Introduction: Hope is an important factor in quality of life assessment, which indicates for the positive expectations for the future. Hope is intrinsically linked with palliative care for patients with advanced cancer.
Patients and methods: Quality of life was assessed in 50 advanced cancer patients at the In-patient Palliative Care Unit in Pleszew (30 women and 20 men) with McGill Quality of Life Questionnaire, own Hope Questionnaire and exploring hope by Osgood's Semantic Differential. The hope components include: control scales 4 items, situation factor (health) 8 items, temporal factor (future) 8 items, intrapersonal factor (religious faith) 8 items, emotional factor 8 items.
Results: There is a significant difference between hope intrapersonal factor (faith) in the struggle with disease-induced stress - for women it was significantly more important (chi square test $p<0.015$), the level of education also has significant impact on this factor - patients with the lowest (basic) level of education have the highest scores regarding faith ($p<0.043$). The higher level of hope was significantly connected with the better support. There is a positive correlation between the level of quality of life and all aspects of hope: control scales, situation factor (health), temporal factor (future), intrapersonal factor (faith) and positive emotional state.
Conclusions: This study confirmed the positive correlation between well-being, quality of life level and hope, which may be a target of a psychological intervention.

PE 2.S399

Definition and elements of core attitude in palliative care - Results of a representative survey of professionals in palliative care in Germany

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Background: Palliative care (PC) is a discipline that requires specific competencies, skills and attitudes of professionals in the care of the dying patient. Core attitude can serve as a label describing the professional's self-image.
Objective: The study aimed to describe how PC professionals describe their core attitude (in general and in PC work) and to identify certain features of core attitude.
Methods: We conducted a survey with 5 open questions as well as socio-demographic data was administered. Participants were asked to describe their understanding of the term core attitude. 350 professionals (physicians, nurses, social workers, psychologists) of 63 palliative and hospice care institutions (inpatient and home care) in Germany completed the questionnaire (51.31% response rate). Data were analyzed using qualitative content analysis.
Results: When asked to describe their attitude in the work with dying patients, professionals named elements and features which could be grouped into three topics:
(1) personal characteristics (i.e. confrontation with death and dying, calmness),
(2) values (i.e. openness, honesty, respect), and
(3) skills in the care of the patient (i.e. empathy, being present, respecting autonomy).
Participants' descriptions of the term core attitude could be classified into the following categories:
(1) image of man,
(2) basis of action,
(3) belief,
(4) life philosophy,
(5) personality and
(6) attitude.
Whether the concept refers to 'attitude' in the sense of 'opinion/ judgement' or designates a 'stance' or a certain 'mindset' was discussed controversially. Sample characteristics such as gender, working field, and occupational group show differential influence on personal concepts of core attitude.
Conclusion: Core attitude seems to be a feasible concept for heightening awareness of personal goals and ethical influences in the care of the dying. It may serve as a label subsuming important competencies in PC work.

PE 2.S400

Core attitude in different working fields - Results of a representative survey of professionals in palliative care in Germany

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Background: Palliative care is a discipline that requires specific competencies, skills and attitudes of professionals. 'Core attitude' describes the basis of actions and thoughts in the work with dying patients.
Objective: The aim was to describe the change of core attitude through work experience and to evaluate the potential influence of setting (PCUs, hospice and home care) and profession (physicians, nurses, social workers, psychologists).
Methods: We conducted a survey with 5 open questions as well as socio-demographic data. 350 professionals (physicians, nurses, social workers, psychologists) of 63 palliative and hospice care institutions (inpatient and home care) in Germany completed the questionnaire (51.31% response rate). Data were analyzed using qualitative content analysis. After development of meta-categories, group differences were analyzed for significance (Chi-square test and contingency coefficient).
Results: 36.5 % of professionals denied a change of personal core attitude after beginning to work in PC. Those participants who support a change in core attitude, specified areas and elements of change such as:
(1) to set priorities,
(2) holistic viewing,
(3) calmness,
(4) fulfilment in work,
(5) self-reflection
(6) emotions,
(7) values, and
(8) support of the patient.

Preliminary analysis showed that gender and setting have a significant relationship to frequencies with which categories were assigned, i.e. professionals in PCUs and inpatient hospice services named support of the patient as most important area of change (?2= 10.6; p< .03). Further analysis and results will be presented at the conference.
Conclusion: Almost two-third of the participants stated that their core attitude had changed since they started working in PC due to work experience. Working field and setting are related to areas of change.

PE 2.S401

Social support of patients, family members and professionals in palliative care

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Background: Social Support plays an important role in coping with death and dying. However, research lacks a systemic view because it mainly focuses on only one setting or one group of persons.
Objective: Study examines social support of patients, family members and professionals in six different kinds of institutions. Focus lies on interaction and comparison of these three groups influenced by their institutional setting.
Methods: Quantitative analysis of a survey with 765 participants in 58 institutions (oncology units, palliative care units, intensive care units, nursing homes, hospices and outpatient care services). The University of California Social Support Inventory (UCLA-SSI) was applied in modified form. Data was analyzed by frequencies, correlation measures and Oneway ANOVA using SPSS for Windows.
Results:
1) Patients and family members both report to give and receive social support from each other.
2) Compared to patients and professionals, family members describe to receive less social support.
3) Professionals mention colleagues as important source of social support.
4) Satisfaction of professionals with supervision as way of social support varies highly across institutions and professional groups: Volunteers, mostly working in outpatient care services, are most satisfied with the supervision received. Doctors are either very satisfied or not at all satisfied, nursing staff is evenly distributed.
Conclusion: A systemic perspective in intervention is highly recommended, e.g. taking into account the close relationship between patients and family members. Social support of family members should be improved. Concerning professionals social support among colleagues should be facilitated, e.g. through appropriate design of working time schedules and work spaces.

PE 2.S402

Communication and decision making as professional skills - Results of a representative survey of professionals in palliative care

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Background: In palliative care (PC), relational competencies represent an integral part of professional skills and attitudes. However, an instrument to assess aspects and dimensions in professional communication and decision making in pc is still lacking.
Objective: The study aims to describe professional skills in communication and decision making (1). Furthermore, their influence on strain and well-being in the professional environment is examined (2).
Methods: Quantitative analysis of a survey with 381 pc professionals. The Checklist PK (professional medical communication) and the OPTION scale (communication skills in decision making) were applied in modified form. Data was analysed with descriptive evaluation, analysis of variance (ANOVA), correlations, factor and regressions analysis using SPSS 15.0.
Results:
Ad (1): The factor analysis identifies 4 dimensions of skills concerning communication and decision-making: the behavioural, verbal, emotional and cognitive dimension. The analysis of these dimensions shows: the verbal dimension is closely related to the emotional dimension (r=.610***), as well as the behavioural to the cognitive dimension (r=.523***).
Ad (2): The cognitive dimension shows no influence on strain/well-being in the pc context. The emotional dimension is related to the importance of work (p<.001), aversions to the patient (p=.001) and inner peace/ balance (p<.001). The behavioural dimension has influence on the importance of work (p=.001) and on the experience of occupational success (p<.001).
Conclusion: The study shows the relevance of professional skills in communication and decision-making. The items that were modified and used here can serve as a basis for the construction of a communication evaluation tool for the medical and pc context.

PE 2.S403

Public awareness of palliative care in Romania

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Background: Palliative care has developed significantly in Romania in recent years, but there is still huge potential for growth. Expansion of service provision throughout the country faces a number of barriers, not least a lack of public awareness of palliative care.
Aims: This study aims to assess public awareness of palliative care, before and after a countrywide awareness campaign.
Methods: A questionnaire survey was designed by hospice experts and applied by an independent market research company to a stratified random sample of the Romanian population, who were interviewed at home. Following collection and interpretation of results from the first survey, a nationwide awareness campaign was designed and delivered, including a media-clip for television and radio broadcast and articles in the local and national press. The initial questionnaire survey was then re-applied to a second population sample and the results of both surveys were compared.
Results: 1233 individuals completed the initial survey. Less than 1% had a correct understanding of palliative care or hospice, although 12% of respondents had previously cared for someone in the terminal stages of illness and 9% reported another member of the household having had to care for a terminally-ill patient. The second survey addressed 1250 individuals and a similarly low level of awareness was reported, with only 1% able to correctly define palliative care.
Conclusions: There is clearly a very poor awareness of palliative care in the general population in Romania, which was unable to be addressed effectively with a relatively short media campaign. This campaign confronted a number of barriers and difficulties - local elections and national parliamentary elections coincided with the campaign period, the NATO summit in Bucharest affected mass media coverage significantly and time constraints also limited its efficiency. Further measures need to be taken to improve understanding and awareness.

PE 2.S404

Withdrawn.

PE 2.S405

Palliative cancer patients' experience of attending group exercise training

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Physical exercise has recently become more common as part of oncology rehabilitation and is also proposed for use in palliative care. Results from pilot studies show that advanced cancer patients are able and willing to attend in group exercise and they report increased well-being and less fatigue after a period with exercise training. However, no published studies have used qualitative design to investigate the patients own experience in attending group exercise. The aim of the present study was to explore how patients with incurable cancer disease experience attending a physical exercise programme at the hospital. A purposeful sample with regard to age, gender, diagnoses and performance status was made. Ten patients with different cancer diagnosis were interviewed. A qualitative design with audio-taped semi structured interviews was used. The findings identified important themes such as "maintain and improve physical function", "makes routines in every day life", "motivation from the physiotherapist and other patients being in the same boat", "positive commitment and motivation to start exercise that was difficult on their own" and "increased energy". The findings indicate that attending group exercise gave the patients meaningful tasks and made them structure the day. Several patients expressed they had no initiative to be physically active by themselves, so this was a golden opportunity to be more physically active. The physiotherapist was important in making the patients secure in what activities that was safe for them. In conclusion, palliative cancer patients express a benefit from attending in group exercise training. It gives the patients energy and helps structure the day.

PE 2.S406

Art therapy effectiveness on pain and others symptoms for palliative care inpatients: A pilot qualitative study

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Aim: Many complementary therapies as relaxation, massage, music therapy, have been reported to be effective in reducing symptoms and improving quality of life. Art therapy is a clinical intervention based on the use of art's medium to create an healing relation. It allows to help patients by distracting them from their symptoms and usual cares.
The main aim of this study was to evaluate the effect of one-hour art therapy session on different symptoms (pain, nausea, fatigue, anxiety, depression...).
Method: A qualitative study was carried out to determine art therapy session's perceptions and effects. Semi-structured interviews were carried out over a three-month period by the first author. The interviews were guided by a prompt list to ensure that the same issues were discussed at each interview.
Results: Twelve patients were interviewed. Patients find art therapy was soothing and relaxing but also stimulant. Art therapy was reported to increase desire to do but also fatigue. It allows them to take back with their family.
Conclusion: This pilot-study confirm us the evidence for the efficacy of art therapy in reducing symptom as pain, and anxiety and the interest of a qualitative design. But the small sample size of the study, the single-session evaluation limits the implications of theses results.

PE 2.S407

Development of the 'Cardiff communication skills toolkit'

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Aim: To develop simple communication strategies, appropriate to different levels of expertise, clinical setting and cultures.
To teach and evaluate these.
Method: We analysed consultations to establish the key factors influencing a consultation deemed to go well. Reflective analysis was of:
• our experience of teaching communication skills in various settings, including hot review
• our clinical practice, particularly errors
• tutor feedback from teaching 'role play' in culturally diverse clinical settings
• videoed consultations from postgraduates on the Cardiff University Diploma course
• published literature.
We identified 6 key techniques (toolkit) which used appropriately would facilitate any consultation. These were taught on a one day course by lecture and reinforced in 'role play' to an international cohort of 114 doctors and senior nurses.
Each participant was asked to self score their competence before and after receiving the teaching on the communication skills toolkit. Tutors who facilitated the small group role play also scored these participants using the same scoring criteria.
Results: The toolkit comprises appropriate use of
1. Comfort
2. Language
3. Listening
4. Reflection
5. Question style
6. Summarising.

Full matched scoring results are available for 90 participants. The results indicate self scored improvement across all 6 facets; greatest change was in

the 'use of reflection'. The tutors scores mirrored the participants self scoring.
Conclusion: The tool kit clarifies the key essentials of the consultation, recognising the complex scenarios frequently encountered in palliative care. The toolkit does not initially attempt to deliver a fully literate communicator, versed in all nuances of a difficult scenario. But it offers 6 key techniques / tools that can be applied to any consultation and developed as individual skills to improve the role-play and real world consultation, particularly in difficult situations.

PE 2.S408

Preferences and experiences in the communication with physicians - A survey in German patients with life-limiting illnesses

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Aim: To gather views and experiences of German patients on aspects of disclosure and information about life-limiting illnesses.
Methods: Questionnaire (19 items, some subdivided) administered to 152 patients with various advanced neoplastic diseases.
Results: Recalling their first disclosure, 51% of patients described the situation as "sensitive", 26% as "somewhat sensitive" and 22% as "insensitive". 59% could chose who was present, every 7th situation occurred with other patients in the room. When asked to give grades for the overall experience with their counterparts (1=best~"very good", 6= worst) best experiences were graded with 1or 2 by 87% of patients. The remaining ~13% could not recall experiences graded as "good" or better. Worst experiences were 4 or worse for ~60% of patients. The use of the word "cancer" was recommended by 82% of patients, the suggestion of talking about "a growth" or "a lump" (German: "Geschwür" or "Geschwulst") because this would "sound less threatening" was refuted by 50% of patients but at least somewhat endorsed by 30%. The majority of patients (86%) associated a doctor who was occasionally humorous with a feeling of hope, while only 54% associated being "physically touched... to offer comfort" with hope, and for 16% this gesture was explicitly "not hopeful". The interview and the resulting renewed preoccupation with the subject was regarded as stressful ("belastend") for 6.5% of patients and additional 13.5% somewhat stressful.
Conclusion: Given the patients grading of their physician counterparts, there seems to be room for improvement in the communication skills of German physicians. Preferences of patients are similar to results reported from Australia (e.g. Hagerty et al. (2005) JCO 23:1278). The minority preference for terms which "sound less threatening" than "cancer" deserves further study concerning the optimal approach for breaking bad news. Further data and correlative analyses will be presented.

PE 2.S409

Psychological risk factors for colorectal cancer?

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The attempt to identify personality types tending toward cancer in general or specific cancers in particular is of long standing. Yet previous studies yielded inconclusive findings (e.g., Type C). A set of studies focused on identifying relevant personality characteristics of cancer pts has been launched improving on former attempts by applying a new psychological methodology grounded in the cognitive orientation theory and by considering medical variables. The purpose was to identify personality correlates of colon cancer pts. In one study the personality questionnaire was administered to 106 colon cancer pts and 99 matched healthy controls. The statistically significant results showed that the main psychological features of the pts include controlling themselves and others, pent-up anger, increased demands of themselves and striving for perfection. These features were independent of demographic and medical characteristics. These results were confirmed in another study with 230 colorectal cancer pts. Further, differences in the questionnaire scores were found between the genders corresponding to the expected medical differences. Finally the questionnaire was applied to identifying the detected personality correlates in an attenuated form in Crohn pts, known to be at risk for colorectal cancer. Discriminant analysis showed that the questionnaire provided a highly significant correct identification of cases of the three groups (165 healthy controls, 90 Crohn pts and 230 colorectal cancer pts). The personality correlates of colorectal cancer can be summarized as focused on the tendencies for perfect duty performance, and two contradictory thematic pairs: self effacement versus self assertion, and closeness to others versus distancing from others. These tendencies constitute potential sources of tension. It is suggested that the identified personality correlates be considered as psychological risk factors for colorectal cancer.

PE 2.S410

The Kawa Model - As a communication tool

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Background: Working as an occupational therapist with palliative patients gives many complex meetings/situations. As an occupational therapist we try to enable better flow in the daily living. In occupational therapy we have many models of practice. One model is the Kawa model that aroused from the need of an alternative framework in Asia with their cultural perspective. The Kawa model is a relatively young and growing model in other cultures such as ours. Kawa is the Japanese term for "river" and is a metaphor for live flow through time and space. In the river there are inseparable parts such as rocks (life circumstances), walls and bottom (environment) and driftwood (assets and liabilities) that determines the river shape and flow.
Aim: We need a more comprehensive and holistic dimension of the inner self and environmental mapping to meet the actual needs for the palliative patients. The aim was to see if the Kawa model could be used as a tool to provide this.
Method: We introduced the Kawa model to the patients through verbal and visual instructions. The patients where thereafter told to make a drawing of their own river context. The occupational therapist and the patient where in a constant dialogue during the session.
Result: This way of using the model was a really ice-breaker regarding these sometimes serious and delicate questions. It clarified the patient's strengths as well as problems and provides a visual context in the process of seeking solutions, goals and expected outcomes. Both the occupational therapist and the patient gained a deeper understanding of the life circumstances through the patient's drawing and telling his/hers own stories.
Conclusion: We believe that the Kawa model is a very suitable tool, theory and procedures that will allow us to gain a deeper insight into the palliative patient's life flow in a holistic and client centred way. The Kawa model also helps the patient to understand what occupational therapy can provide.

PE 2.S411

Influence of the caregiver age in the pact of silence

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Aim: The pact of silence is defined as the agreement to alter the patient information from relatives, friends or health professionals, with the aim of concealing the diagnosis, prognosis or severity of the situation to the patient who wants know what happens. The aim of our study is to know:
- The prevalence of the conspiracy of silence in our PCU.
- The consistency between the desire to be informed about the disease as a patient or as a main caregiver.
- The differences in the reasons that lead caregivers to hide the disease to the patient.
Method: Descriptive qualitative study.
Questionnaire with 22 questions.
Population: Caregivers (age > 60 and < 60) of patients admitted in our UCP with positive criteria of pact of silence.
Statistical analysis of results with the program SPSS 11.5.
Results (preliminary):
Caregivers < 60 years:
Average age: 41.8 years
76.6% women
If you had a terminal cancer, would you like to know it?: YES: 66.66%; NO: 33.33%
Reasons for not informing the patient:
- 80% I´m not able to tell him
- 76% He would discourage
- 40% He would be more nervous
Caregivers > 60 years: Average age: 70.55
70% women
If you had a terminal cancer, would you like to know it?: Yes: 30%; No: 70%
Reasons for not informing the patient:
- 90% I´m not able to tell
- 80% He would discourage
- 30% He would be more nervous.
Conclusions: The prevalence of pact of silence has decreased at our PCU from 16% in 2006 to 12.6% in the same period of 2008.
66.66% of caregivers < 60 years would like to know the diagnosis and prognosis of their disease, while only 30% of caregivers aged over 60 would like to know it.
There aren't statistically significant differences in the grounds of pact in connection with the age of the primary caregiver.
The inability to talk about the prognosis of life and fear at despondency of the patient are the most frequent reasons that justify the concealment in both groups.

PE 2.S412

Improving feasibility of clinical trials in palliative care: A proposed model

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Background: Successful conduct of clinical trials in palliative care has been plagued by low accrual rates, high attrition of study patients during trials, and challenges related to managing co-morbidity and other factors. A range of approaches to evaluate feasibility have been used to appraise the practicality of research in a particular area of inquiry. A formal feasibility study, if appropriately conducted, can provide enormous insight into the design and conduct of a larger, definitive clinical trial.
Methods: A MEDLINE search was undertaken using the MeSH term ´feasibility studies´ linked with the terms: palliative care; terminal care; and end of life. References within identified articles were also reviewed. The final 17 articles were synthesized into a feasibility framework and a standardized model to investigate barriers and potential solutions to each. We applied this framework and model to four trials selected from our library of completed studies to provide preliminary validity evidence.
Results: Extensive effort has been expended to identify and characterize barriers to successful conduct of clinical trials in palliative care. Barriers can be broadly categorized into 4 domains: patient-related, organizational, logistical, and barriers that are inherent to the topic being studied. Based on these barriers, and strategies recommended to address them, we developed and tested (a) a framework to help predict the numbers of patients needed to be assessed in order to achieve a given study's accrual targets, as part of (b) a comprehensive model to prospectively investigate feasibility.
Conclusions: Challenges to successful completion of palliative care trials are prevalent and serious. A clear taxonomy to characterize the eligible patient pool, and a model of approach by which feasibility is systematically investigated, hold the promise to enhance the effectiveness of scarce resources applied to palliative and end of life research.
Funding: CIHR Grant PET69772.

PE 2.S413

Therapy management decisions by means of F-18-FDG PET/CT in patients with recurrent rectal cancer

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Aims: Although the rate of local recurrence after multimodality treatment for primary rectal cancer has decreased considerable since the introduction of total mesorectal excision, up to 33% of patients develop a locoregional relapse. Until now, the role of diagnostic imaging for routine follow-up remains still ambiguous. This study aimed to confirm the benefits of F-18-FDG PET/CT for evaluation of patients (pts.) with clinical/CD-suspected recurrence of rectal cancer.
Methods: 37 pts. (xm:64.9 y.;8 f, 29 m) underwent CD (MDCT,MR,endoscopy) and whole body contrast enhanced 4-row helical PET/CT (GE Discovery LS). For CD diagnosis major criteria (histology,bone destruction) and minor criteria (progressive soft tissue mass on repeat MDCT, invasion of organs, typ. appearance in EUS) are used, for PET focal FDG-uptake (SUVmean > 2.0). Pts. records, tumour specific data, therapy after primary treatment were collected and therapeutical consequences evaluated based on PET/CT results compared to decisions based only on CD.
Results: PET/CT highlighted in 59.4% (22/37) ín contrast to CD tumour progression. In this subgroup pts. are classified at time of primary surgery as T3-4 N+. PET/CT detected in 17/22 pts. local recurrence and lymph node involvement ± distant mets., in 22.5% (5/22) PET/CT was the method of choice to select pts. for curative treatment. Based to PET/CT results therapy consequences are made: 8/22 pts. received a radiation therapy, in 14/22 pts. chemotherapy was administered. In 40.6% (15/37) PET/CT excluded the suspected local recurrence/tumor progression, therefore no further investigations and additional costs have to be considered.
Conclusions: F-18-FDG PET/CT and MDCT have both the potential to directly visualize local and distant relapse of colorectal cancer. Influence of therapeutic management decisions in patients with recurrent rectal cancer based on PET/CT results compared to MDCT are on significance.

PE 2.S415

The challenge of end of life care research: Reflections on the use of an observational research method

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Aim: To develop a suitable research method to examine hospice staff decision making at the end of life.
Method: Performing research in palliative care can be difficult with practical & ethical challenges. This is especially true of end of life care research, where ethical concerns and minimum impact on patient care are paramount. While developing a project to study hospice staff decision making when recognising the dying phase, a number of taxing methodological problems were identified. The greatest challenge was how to balance theoretically ideal method with the reality of research in an end of life clinical setting. Observations, as part of qualitative study can provide insight into decision making. However direct observation of clinical staff when performing care of dying patients leads to concerns regarding impact on patient care and patient consent. A modified observation phase was designed, proposing observation of hospice multi-disciplinary team and ward handover meetings, where clinical decisions are discussed and communicated amongst staff away from episodes of direct patient care.
Results: The project was successfully reviewed by local Research Ethics Committee (REC). The REC required all staff present at observed meetings must consent to being observed. Overall consent rates were high, allowing attendance at all MDT meetings during the 6 week observation period. Attendance at ward handover meetings was harder given the changing nature of nursing shift patterns, the large number of staff present & REC requirement for a minimum period of 24hrs for staff to decide whether to participate. Where attendance was possible, useful information for the research project was obtained.
Conclusion: Given the challenging nature of end of life care research, a pragmatic approach to project design must be considered. This use of observational research can provide useful insight into staff decision making at the end of life, but is affected by practicalities regarding consent.

PE 2.S416

Feasibility study of Transcutaneous Electrical Nerve Stimulation (TENS) for cancer bone pain

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Aim: To assess feasibility of conducting phase III trial of Transcutaneous Electrical Nerve Stimulation (TENS) in patients with cancer bone pain.
Methods: Multicentre randomised controlled crossover design. Eligible patients recruited from palliative care services received active or placebo TENS for one hour at the site of pain then crossed over; median interval between interventions 3 days. Responses assessed at 30 and 60 minutes included numerical (NRS) and verbal (VRS) ratings of pain at rest and on movement, and pain relief. Recruitment, tolerability, adverse events, and effectiveness of blinding were also evaluated.
Results: Twenty-four patients were randomised and 19 completed both interventions. Five patients withdrew: three due to deteriorating performance status, two due to increased pain (one following active TENS and one following placebo TENS). After one hour of TENS and adjusting for baseline; mean NRS pain score at rest with active TENS was 2.11, and for placebo TENS was 1.79 (difference=0.32 [95% C.I. -0.79, 1.43]); mean NRS pain score on movement was 2.84 for active TENS and 3.05 for placebo TENS (difference= -0.19 [-1.28, 0.90]); mean NRS scores for pain relief were 52.6 with active TENS and 38.4 with placebo TENS (difference=14.2 [-2.17, 30.57]). Nine patients did not consider that a placebo was used though the remaining ten correctly identified placebo TENS. The intervention was well tolerated in this population.
Conclusion: Feasibility studies are important in palliative care prior to undertaking clinical trials. Our findings suggest that further work is required on recruitment strategies and refining the control arm before embarking on a phase III trial of TENS in cancer bone pain. Confidence intervals suggest using movement related pain intensity or pain relief as primary outcome measure is most likely to detect any benefits of TENS in this context.
Funding: Cancer Research UK.

PE 2.S417

Why trials fail in effectiveness research in palliative care

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Aim: It is generally acknowledged that research in palliative care, especially well-conducted controlled clinical trials, is difficult. The aim of this study was to collate and highlight the reasons why trials in palliative care fail.
Methods: Trials were identified using a broad search strategy from a number of electronic databases: Embase (1988-2008); Medline (1966-2008) Cinahl (1982-2008),Cancerlit (1962- 2008) The Cochrane Database of Systematic Reviews 2008 Issue 4. Hand searches of a number of palliative care journals were also undertaken (Palliative Medicine, Journal of Pain and Symptom Management, Progress in Palliative Care, Journal of Palliative Care, Journal of Palliative Medicine) In addition, abstracts from posters and oral presentations of the European Palliative Care Conference, the Research Forum of the European Association of Palliative Care, the Palliative Care Congress (UK) and the research meetings of the Palliative Care Research Society. No restriction was placed on the language of the original article.
Exclusions: Evaluations of psychosocial interventions or assessments of services; treatments which would not normally be instituted or delivered by a palliative physician.
Inclusions: Randomised clinical trials of effectiveness research in patients with advanced incurable doisease.
Results: 1621 papers were retrieved but only two yielded information related to trial failure. The principle reasons for failure of trials fell largely into the following categories:
1. Difficulties in patient accrual and attrition
2. Lines of accountability
3. Study protocol difficulties
4. Ethical gatekeeping by health professionals
5. Lack of enthusiasm for research among health professionals
6. Lack of resources.
Conclusion: Success in future trials requires the lessons of previous trials to be learnt. A database of research failures and amnesty on such information may benefit researchers.

PE 2.S418

How to explore what people really want to say with an advanced directive

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Background: Dealing with advance directives (AD) in clinical practice is not free of legal and practical problems. Furthermore, there are no empirical data on how adequately a written AD expresses a person's actual preferences for end-of-life care (EoLC). This study developed a mixed method approach to compare the content of ADs and what persons really wanted to declare in their AD.
Aims: 1. Systematic analysis of congruencies and incongruencies between ADs and interviews, forming the basis for identification of key problem areas in formulating an AD.
2. Identification of group differences between healthy (H), chronically ill (CI) and persons receiving palliative care (PCP).
Methods: A semi-structured interview following an interview guideline was used to elicit actual preferences. Content analysis of the interviews and of the ADs was used to compare terms used and values described.
Results: Thirty seven interviews have been performed (19 H, 17 CI, 1 PCP; 11 male; mean age 63.4 years (55 - 70)) with a mean duration of 25:04 (12:31 - 63:10) min. First results of the analysis show congruencies and incongruencies between ADs and interviews. Incongruencies were mostly found with regard to validity (V), health care proxy (HCP) and personal values (PV). Examples: Statement in the interview that the AD contains appointment of HCP (not incorporated); AD contained HCP (statement in the interview: HCP does not know this). Validity: Interview: Rejection of certain invasive measures, with the exception of emergency situations (AD: general rejection, no specification for emergencies). PV: Finds it important that family members support each other (AD: Does not want any help from family).
Conclusions: Due to the adaptation of methods from different disciplines, this first step within the mixed method approach seems to be a useful instrument in order to explore if ADs truly reflect people's wishes for EoLC.
This project is funded by German Research Foundation, no. NA 780/1-1

PE 2.S419

Oral history and photography with patients in supportive and palliative care

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Aims: To provide an audio and photographic life story service for patients capable of enriching their experience whilst receiving palliative care.
Background: This project is recording life stories and engaging in photography with patients to enable their involvement in producing life history as a record for families. Recordings capture and preserve the unique voice of the individual and remembering can reinforce identity at a time when life circumstances are rapidly changing. Life history work can help patients feel appreciated as people, and help practitioners to

understand patients more fully and form closer relationships. Patients work with a professional photographer to produce deeply personal images. Photographic images are sensitive representations which aim to capture individuality and identity. Oral history and photographs combine to give 'a voice, a face and an identity' to people who, due to their disease condition, may find it difficult to communicate their individuality.
Method: Oral history recordings are created in an informal session in which the patient is prompted to recall their life story. Reflection on significance and meaning of events enriches life stories. A copy of the recording is made after the interview and given to the patient. The recording is the patient´s property and available for research with their consent. Recordings are stored securely and made available to family and friends with the patient's permission.
Results and conclusion: Outcomes for patients include raised self-esteem, sense of worth, attaching meaning to life experiences, creation of a personal family record, and recognition and validation of experience. Outcomes for clinical practice and research include better understanding of living with life-threatening disease, awareness of impact on identity and lifestyle, raised awareness of experiences of palliative and wider health care, and insight into relationships between patient, family and professionals.

PE 2.S420

Is the integration of non-scientific literature helpful for systematic review on phenomena in the last days of life?

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Question: The identification of phenomena of approaching death and its prognostic value are basic for diagnosing dying. Research during the last days of life remains ethically difficult and scientific data for signs and symptoms for diagnosing dying are consequently rare and questionable. While reviewing the literature on this purpose within the OPCARE9 collaboration, the question was posed if the integration of non- scientific literature may contribute more information to this situation.
Methods: German non-scientific literature is screened by internet search and a random library sample using keywords comparable to the systematic review. The findings were compared with the results of a pilot systematic review on signs and symptoms of approaching death and with results of a first round Delphi process on the same issue.
Results: Whereas change in respiration (33%) and consciousness (24%), reduced fluid intake (21%) and other signs (heart rate etc., 20-24%) are the predominant signs and symptoms in the literature and in the Delphi among professionals, other problems or phenomena are reported in the non- scientific literature and non-professional Delphi: increase of pain (28%) and fatigue/ retrieval from life (25%).
Conclusions: Preliminary results of the systematic review show a possibly important difference in phenomena predicting death and dying between the scientific and non- scientific literature. Researchers in Palliative Care may miss important information especially for the phase of death and dying if during the search for "grey literature" non-scientific literature such as guides, fiction and documentary films are not reviewed.

PE 2.S421

Nasal Fentanyl for the treatment of severe dyspnoea - The perfect symptom control for home-care?

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Severe breathlessness is a common and distressing symptom in advanced malignant and non-malignant disease. There is good evidence for the systemic use of opioids to relieve breathlessness but not for the nebulized route. The route of administration and the time to onset play an important role in selecting an ideal agent. Ideally, any drug used for episodic breathlessness should be easy to use both for patients and relatives with rapid onset giving quick symptom relief in any setting and professionals available.
Over recent years nasal administration of drugs has attracted both clinicians and researchers. This route has various advantages such as ease of administration, rapid onset and patient control.
In 2003 our palliative care team developed the use of intranasal Fentanyl as standard medication against episodic and severe breathlessness. Usually breathlessness is one of the most frequently reasons for unexpected and unwanted hospitalisation at the end of live. Since we use nasal Fentanyl against episodic severe breathless almost all of our patients could stay at their home until they died. None had to go into hospital because of the symptom breathlessness itself!
In total about 400 patients have been treated with nasal Fentanyl.
It seems that PalliativNetz Osthessen is the only palliative care team using large-scale nasal Fentanyl against breathlessness. We want to present the tastk, method and recent statistic about our treatment and discuss the advantage and riscs of nasal Fentanyl against severe breathlessness.

PE 2.S422

Can "steroid switching" improve steroid-induced psychosis in an advanced cancer patient?

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Aims: To examine the effectiveness of treatment of steroid-induced psychiatric symptoms by steroid-switching.
Methods: Case history.
Results: The patient was a 67-years-old man. He had a history of pulmonary emphysema In January of Year X-1, he was diagnosed with malignant pleural mesothelioma and admitted to our hospice on August of Year X. On October 20, oral prednisolone (5 mg/day) was started to reduce bronchial secretions and was dosed up to 10 mg/day on December 13. In addition, oral prednisolone was switched to intravenous betamethasone (2 mg/day) on January 17. No psychiatric symptoms had been observed during the period of the prednisolone administration.
On January 20, Year X+1, he began to show disorientation, restlessness and unusual behavior. On January 24, betamethasone was discontinued because of concern about the adverse effects. On the following day, intravenous prednisolone (10 mg/day) was begun to replace betamethasone. On February 1, intravenous prednisolone was switched to oral prednisolone (10 mg/day). On February 2, his expression appeared vital again and his speech and behavior became almost normal. Subsequently, oral prednisolone was continued at the same dose, but no psychiatric symptoms appeared.
Discussion: We reported a case of steroid-induced psychiatric symptoms who was treated by switching from betamethasone to prednisolone. To our knowledge, there were few reports on effectiveness of treatment of steroid-induced psychiatric symptoms by switching from one steroid to the other.
In palliative care, "opioid switching" is frequently selected in order to improve the balance between analgesia and adverse effects. In the same way "steroid switching" may improve adverse effects, as seen in this case. Although treatment of steroid psychosis is dosage reduction or discontinuation of steroid and concomitant administration of psychotropics, "steroid switching" may serve as a valid alternative treatment.

PE 2.S423

A retrospective review of the use of pregabalin in a palliative medicine outpatient department

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To review the use of pregabalin in the outpatient setting, in particular to record the indication for pregabalin prescribing, the starting and average doses prescribed, co-analgesic usage, tolerability and side-effects.
Retrospective chart review was undertaken for all patients attending the Palliative Care OPD in Galway University Hospitals over one year. The number of oupatient attendances was noted, and data recorded from each visit.
Of the 160 patients attending outpatients, chart data was available from 97 charts. 60 of 97 patients (62%) were on pregabalin. 39 patients (40%) were already on pregabalin at their first recorded outpatient visit. Of the 58 patients (60%) not on pregabalin, 15 patients (26%) started on pregabalin at the first outpatient visit, 4 patients (7%) at the 2nd visit and 2 patients (3.5%) at the 3rd visit. The chief indication for starting pregabalin was nerve compression. Pregabalin was also prescribed for ospteoporosis/osteoathritis, hiccups, chemotherapy-induced neuropathy, peripheral neuropathy and tenesmoid-type pain. Typical starting doses were 25mg bd (43%), 50mg bd (43%) and 75mg bd (14%). A trend towards gentle dose increase over time was seen, with an average dose once established on pregabalin of between 100 and 150mg bd. An initial decrease in opioid dose was observed in a proportion of patients, presumed to be those that had a large neuropathic component to their pain. At subsequent visits there was a slow rise in opioid dose. Co-analgesic usage was also recorded with a trend over time towards increased prescribing of NSAIDS, amitryptiline and anti-depressants. 12 of 60patients (20%) stopped pregabalin, most commonly (7patients) due to intolerance (dizziness, tremors/myoclonus).
Pregabalin is widely used in our service, with typical starting doses of 25 or 50mg bd and an average dose once established of 100 to150mg bd. It is generally well-tolerated; chief side-effects include dizziness and tremors.

PE 2.S424

Use of tunneled pleural catheters for treatment of malignant pleural effusions

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Background: Malignant pleural effusion (MPEs) is a common complication in advanced malignancy.
Aim of the study: Explain our experience using tunneled pleural catheters (TPCs), in the treatment of the dyspnea relation with the MPEs.
Methods: This is an observational, descriptive and retrospective study. We have reviewed the medical histories of the patients treated with TPCs from January/06 until May/08. Adults oncologycs patients with symptomatic MPE, attended by Oncology Service and/or Palliative Care Unit.
Results: We have included 18 patients (12 men and 6 women) and 23 insertions procedures. The average age is 68.9 years. 50% of the patiens had a lung neoplasm, 27.7% of them had a pleural mesothelioma and the rest included diferents types of tumors. No complications in 47.8% of the insertions procedures. 13% of themdeveloped pneumothorax, accidental removal and infection insertions respectively. After the insertion procedure, 2 patients stayed alive less than 10 days , 6 of them from 10 to 30 days , 3 of them from 30 to 50 days and 3 patients more than 50 days. Only 2 patients are alive by the end of the study, without catheter, and we lost contact with 2 of them during the monitoring.
Conclusions: Dyspnea is the main cause of insertion catheter in our patients. The insertion of TPC is the second used technique. Nearly 50% of the insertions procedures catheters didn't develop complications.
55% of the patients stayed alive more than 30 days after the insertion procedure.
In selecting an appropriate intervention, clinicians should consider local expertiser, the patient's clinical status, the type of tumor and disease stage, patients comorbidities, life expectancy, ongoing therapies, and the patient's autonomy in order to make an informed decision.

PE 2.S425

Living with breathlessness: How does it affect the sleep patterns of patients & their caregivers and how can we help?

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Background: Breathlessness is a complex & distressing symptom that affects the quality of life of both patients with advanced disease & their carers but it is unclear how breathlessness is experienced at night and how sleep patterns are affected.
Aim: To explore the experience of sleep in breathless patients with heart failure or lung cancer and in their main caregivers.
Methods: In-depth qualitative interviews were conducted with patients and their caregivers as part of a larger study on breathlessness across different settings and conditions. Secondary qualitative analysis of this dataset was performed. Data from the transcripts was coded using NVIVO and analysed using the Framework approach.
Results: 12 breathless patients & 12 caregivers were

included. Most patients experienced sleep disturbances, which they perceived to be related to symptoms, particularly breathlessness, side effects of medications used for breathlessness, thoughts and external factors such as noise. Most caregivers had experienced sleep disturbances at some stage during their caregiving. Reasons given for carer sleep disturbance included nocturnal 'vigilance' & anxiety, previous perceived 'poor' sleep patterns and patient restlessness during the night. Few patients or carers had approached healthcare professionals about their sleep problems. However many had adapted their lifestyles to cope with sleep disturbances.
Discussion: Sleep disturbances affected both breathless patients and caregivers. Carers' sleep experiences shared similarities with those of shift workers & new mothers. Few patients or carers had approached healthcare professionals feeling that sleep disturbances were either not worth mentioning or that little could be done to help. Healthcare professionals need to recognize that patients & carers underreport sleep disturbances and target appropriate interventions. Models of the factors associated with sleep disturbance & areas for targeting interventions will be displayed.

PE 2.S426

Artificial hydratation and nutrition at patients with advanced oezofageal cancer

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Aims: The effect of the use of artificial hydratation and nutrition at patients with oezofageal cancer in palliative stage.
Methods: In 2001-06, total of 10 patients with oezofageal cancer were treated in Sue Ryder Hospice. All were man, age 52-84 and were former smokers and had been using large quantities of alcohol. 4 of them were with placed gastrostome as a way of nutrition, at one we initiated placement of gastrostome and at others it was not indicated placement because of advanced MS changes.
Results: Patients, who were fed through gastrostome, had gained body weight an average one kilogram per month. There were improvements of protein status and blood results as well as better quality of life. From side effects - at 2 of them there were skin irritations around stoma, which were fast recovered, and there were some physiological moments - patients did not feel the flavour of food. Extension of life at patients with gastrostome was on average 9 months. Patients were gastrostome was not placed, were hydrated intravenous with the application of infusion crystalline solutions and also with amino-acids solutions and human albumins. As a side effects at all of the patients there were appearances of tromboflebitis and obliteration of peripheral vein and need of placement of central vein catheter. On average survival at these patients was 3 months.
Conclusion: Purpose of the artificial hydratation and nutrition in palliative stage was to improve the survival, to prevent intense lose of body weight, to prevent absorption pneumonia and appearance of kidney insufficiency. The attitudes about the use as a way of the extension of life of terminal ill with oezofageal cancer from ethical perspective are different in medical circles and also among the patients ant their families. This is determined by culture and population mentality to a great extent. During the process of decision we were managed by cancer advancements, forecasts, expectations of the patients and their families.

PE 2.S427

Subcutaneous Methlynaltrexone (MNTX), a novel approach to the adjunct management of opioid-induced constipation (OIC) in the advanced cancer patient: Report of long-term treatment in 2 patients

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Background: OIC is a prevalent problem that can significantly contribute to symptom distress and decrease quality of life in the advanced cancer patient. MNTX is a peripherally acting opioid- receptor antagonist, which has restricted ability to cross the blood brain barrier and therefore does not appear to affect analgesia or precipitate opioid withdrawal. It has been reported to reverse OIC. There is limited reported data available on the long-term use of MNTX every 2 days in the advanced cancer patient.
Aim: Report of long-term use of MNTX in advanced cancer patients.
Methods: Retrospective chart review, based on telephone follow-up over a >6 month period. Patients were assessed for previous laxative regimen, concurrent laxatives, time to laxation post injection, frequency of bowel movements, and adverse events (dizziness, nausea, cramping) rated on a 0-10 scale (0=no symptom, 10=worst possible symptom). When available, constipation scores based on abdominal x-ray were reported.
Results: A 27 year old male with anaplastic oligoastrocytoma (1) and a 61 year old male with metastatic small cell lung carcinoma (2) were treated with MNTX 12 mg sc every 2 days for 6 and 4 months, respectively. (1) was treated exclusively on an outpatient basis, while (2) started treatment as an outpatient but was later admitted to a hospice. Laxation was achieved in (1) 30 minutes-4 hours and (2) 5 minutes-2 hours, following >80% of injections. Concurrent laxative regimen decreased in (1) and (2). Adverse event data is reported for responses in which ratings were obtained: cramping (1) 2-4/10 in 13/15 responses and 8/10 in 2/15 responses, (2) 0-2/10 in 6/6 responses; dizziness (1) 0-2/10 in 14/14 responses, (2) 0/10 in 8/8 responses; nausea (1) 0-3/10 in 14/14 responses, (2) 0/10 in 6/6 responses. Both (1) and (2) expressed satisfaction with the effects of MNTX.
Conclusion: Efficacy, tolerability and acceptability were high with long-term use of MNTX for relief of OIC.

PE 2.S428

Prevalence of symptoms and required support levels (activities of daily living - ADL) of patients under the care of a hospital palliative care support team

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Aims: In 2006 an interdisciplinary hospital palliative care support team was established at a medical centre with 1092 beds in Vienna. The main goal is to support palliative patients and their families within all departments and to advise doctors and nurses in palliative care and ethical issues. From the beginning documentation was developed to describe details of physical, psychological and social needs. In this study we attempted to ascertain which subjective and objective symptoms palliative care patients suffer from and what their needs are regarding support in their daily activities (ADL).
Methods: Between September 2007 and August 2008 403 patients were asked to describe their symptoms and problems in a standardized questionnaire. The objective symptoms were documented by the hospital palliative care support team. In total twenty nine different subjective and objective symptoms were documented. At the same time the needs of patients in their activities of daily living were evaluated.
Results: 237 patients were female and 166 male. The median age was 69 (24 - 96). On average palliative care patients suffered from eight various symptoms. The most common subjective symptoms were weakness/fatigue (90%), anorexia (72%) and dry mouth (57%). Only 31% suffered from physical pain, but 38% from dyspnoea. The most common objective symptoms were anaemia (72%), cachexia (48%) and renal failure (30%). Thirty nine percent of the patients were bedridden, further 43% needed help in mobilization. Forty eight percent need help with food intake, ten percent had enteral or parenteral artificial nutrition. More than half of the patients (51%) were incontinent, 4% of the patients had a stoma. For their personal care 85% needed support.
Conclusion: Consistent with other studies our results indicate that palliative care patients suffer from various severe symptoms and need specialized treatment. In their activities of daily living they need extensive support.

PE 2.S429

Anti-infective drugs use on advanced cancer patients

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Appropriate use of anti-infective drugs is essential in clinical practice. It is important to balance between patient Quality of Life improvements and medical economics. The use of anti-infective drugs on advanced cancer patients has not been well studied in Japan. We conducted a retrospective study to understand the present situation of the use of anti-infective drugs for advanced cancer patients at Osaka University Hospital.
Methods: We investigated all medical records of advanced cancer patients who died at Osaka University Hospital during a period between January and December 2006. We reviewed the medical records for last three months before death.
Results: A total of 71 out of 111 advanced cancer patients (64%) received anti-infective drugs. There were 44 males and 27 females. The mean age was 62±14 years. They had 326 episodes of infection. The purposes of anti-infective drug use were for the treatments of infections superimposed on the primary cancer site (38%), not related to the primary cancer site (15%), compromised host after chemotherapy or transplant (10%), unknown (10%), prevention of infection (4%). Improvement of leukocytosis was achieved by 47.3%, C-reactive protein (CRP) was decreased by 42.2% and patients with fevers declined by 12.4%.
Conclusions: In order to evaluate the benefits of anti-infective drug use in advanced cancer patients, further studies including the examination of symptomatic improvement besides fever as well as cost-benefit analyses are needed.

PE 2.S430

Delirium at the end-of-life: A (re)conceptualization along the physical, psychological, social, and spiritual dimensions of the human person

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Aim: Delirium is common at the end-of-life and has been shown to cause suffering in palliative care. Research and practice in end-of-life delirium operate largely within a symptom management paradigm that emphasizes the biomedical nature of this condition. Palliative care philosophy, however, espouses that problems at the end-of-life be interpreted within a holistic view that recognizes the integrated connections between the physical, psychological, social, and spiritual dimensions of the human person. Therefore, the aim of this poster is to present an analysis of delirium that, while affirming a biomedical perspective, extends also into the existential, phenomenological, and narrative realms of human experience.
Methods: An analysis of literature from a variety of sources, including medical/health sciences, social sciences, and English non-fiction, informed the creation of a concept map that would convey a holistic understanding of delirium.
Results: Several concepts emerged from the analysis as relevant to the delirious experience at the end-of-life, including: communication, connection, control, dignity, family, life-death transition, nearing death awareness, quality of life, suffering, and symptoms. The final concept map visually depicts linkages between each of these concepts and shows how they relate to different dimensions of personhood. Also depicted is an application of two lenses through which the delirium experience can be viewed, the lens of ethics, and the lens of grief and loss.
Conclusion: While a biomedical perspective is crucial in order to investigate causes of and develop treatments for delirium, complementary frameworks promote an understanding of end-of-life delirium as an individual, subjective, and contextualized phenomenon. Such an understanding will undoubtedly prove valuable as we continue to develop ways to work with delirious patients and their families in palliative care.

PE 2.S431

Prehospital emergency treatment of palliative patients with cardiac arrest

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Background: Today prehospital emergency medical staff is confronted with an increasing number of

palliative patients cared for at home in an advanced stage of their cancer disease [1].
Methods: During a period of 24 month we prospectively analysed all emergency medical calls with regard to palliative emergency situations. In the present investigation all cases with unconscious patients were included.
Results: 361 palliative emergency situations could be detected (2.8% of all emergency medical calls). We identified 106 emergency cases related to unconscious patients (1% of all emergency calls; 29% of all palliative motivated emergency situations). Cardiac arrest was found in 83% of these cases (88 patients). Paramedics started resuscitation in 69% of all cardiac arrest situations (61 patients). Prehospital emergency physicians (EP) began resuscitation in eight cases (9% of all cardiac arrest situations). In 19 cases (22%) no resuscitation was started by the EP. According to a „Return of spontaneous circulation", ten patients (11%) were resuscitated successfully. A further eighteen patients were unresponsive due to other causes.
Conclusions: In Germany palliative emergency situations could be found in about three percent of all emergency contacts [1]. Many patients in an advanced stage of their cancer disease do not wish to be resuscitated [2]. However, resuscitation is started in an acute emergency situation mostly due to unawareness of the patient´s will. To avoid resuscitation and a possible lengthening of the dying process advance directives, like "Do not attempt resuscitation" orders seems to be helpful. The integration of Palliative Care Teams seems to be necessary to avoid emergency medical calls. To what extent these results are an expression of the intensive debate on the topic cannot be deduced from our data and is reserved for further investigations.
[1] Wiese CHR et al. Anaesthesist 2007
[2] Georges JJ et al. Support Care Cancer 2005

PE 2.S432

Design of a RCT double-blind, placebo, multicenter, with methylphenidate in fatigue in advanced cancer patients

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Fatigue (F) is the most prevalent symptom in advanced cancer patients, interfering functional capacity, social relations, wellbeing, and quality of life.
Methylphenidate is a central nervous system stimulant that has traditionally been used in cancer patients to manage depression, opioid-induced sedation, hypoactive delirium due to multiorgan failure, and cognitive disorder associated with brain tumors.
Although there is evidence from prospective studies of the efficacy of this drug in cancer-related F, the only one randomized clinical trials gave non-conclusive results. In order to define the real efficacy of methylphenidate in this setting, we design a new clinical trial comparing methylphenidate and placebo in cancer-related F, assessed both by the numeric verbal scale (NVS) included in ESAS (Edmonton System Assessment Symptoms) and the FACT-F, that is the subscale for F of the Functional Assessment of Cancer Therapy (FACT). We will include 92 advanced cancer patients with F ≥ 4/10 (NVS, from 0 to 10) and hemoglobin ≥ 9 g/dl without any cause of F other than cancer or therapy from 3 hospitals. Patients will be randomized to methylphenidate or placebo. Doses will be adapted to response within a range from 10 mg at morning time and 5 at noon, to 50 mg/day. Assessment of response will be performed on days +3, +7, +14 and +21 with ESAS, FACT. Drug-induced adverse events will be checked. The primary endpoint is the intensity of F; we will consider the treatment as effective if F was reduced at last two points in the NVS on day +7. The design of the trial is discussed in this communication.

PE 2.S433

The burden of constipation

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This two stage study evaluated the impact and financial cost of opioid induced constipation in a specialist palliative care unit. Stage 1 involved a review of 387 medical records of patients who died on the unit during a 6 month period, obtaining a detailed dataset of the current treatment pathways for constipation. Data were included from patients constipated on admission or who became constipated, and who were either taking opioids or had them prescribed during their stay. Fifty eight patient records (totalling 70 admissions) complied with the entry criteria and were examined to investigate prescribing patterns.
The findings from the first stage identified no set patterns for oral laxative prescribing and found that neither 43% of patients complaining of constipation nor 41% already taking opioid medication were prescribed any laxative medication prior to admission, an inference being that earlier and more effective intervention could lead to clinical and economic benefits.
The second stage, a prospective time and motion study investigated the direct costs associated with each task in the management of constipation calculating these with respect to staff time and consumable items. Nurses recorded the time taken to perform the administration of oral and rectal laxatives, enemas, rectal examination manual evacuation and after bowel clear up.
The total cost of managing constipation in the unit over a six month period was estimated to be £11,059 (including cost of discussion); the mean cost of managing constipation was £30 per admission (range £21.36-£38.26), with staff time accounting for 85% of the cost. The data were highly skewed with 71% costing £30 or less, but 5% incurring costs in excess of £100 per admission. The burden of managing constipation in this patient group derives more from time spent in routine discussion, and defaecation after care than from individually time consuming, but infrequently performed procedures.
This research was sponsored by Wyeth Pharmaceuticals.

PE 2.S434

Individualization of pharmacotherapy in palliative medicine decreases a risk of occurrence of adverse drug interactions

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Introduction: Post-medication adverse actions constitute a serious problem in pharmacotherapy in palliative medicine. At palliative patients, as a result of the decreased metabolic effectiveness of a liver and excretory function of kidneys, as well as in relation to commonly used poly-therapy the risk of post-medication diseases as well as unwanted interaction of medications is increasing.
Patients and methods: In this work we attempted at individualization of pharmacotherapy with 64 elderly patients, (median age amounted to 72 years), who had been treated with polypharmacotherapy. With all 64 patients the post-medication adverse effects appeared as the result of applied polytherapy, of a very different clinical image. Analysis of administered pharmacotherapy indicated that with 52 patients (81,2%) the adverse effects appeared as an outcome of interaction among simultaneously administered drugs, and in 6 cases (9,4%) were connected with impairment of the liver functioning and/or kidneys, and in 6 cases (9,4%) cases of oversensitivity reaction to the administered drugs occurred.
Results: As a result of individualization of pharmacotherapy, while maintaining effectiveness and safety of applied treatment in 36 cases (56,3%) a number of administered drugs has been successfully reduced by one drug, and in 14 cases (21,9%) two of administered drugs, considered as unnecessary, were discontinued, in 10 cases (15.6%) as many as three medications, which in our opinion were used unnecessarily, were successfully discontinued. In 4 cases (6,2%) where the patients had experienced oversensitivity reactions the drugs were substituted with other brands, obtaining the disappearance of adverse effects patients had been complaining about.
Conclusion: Individualization of pharmacotherapy in palliative care decreases a risk of occurrence of post-medication adverse effects as well as of detrimental interactions of medicines.

PE 2.S435

Usefulness of perospirone for the prevention of nausea related to opioid administration

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Background: To prevent opioid-induced nausea, prochlorperazine is recommended as a first-line drug in Japan. However, the use of the dopamine receptor antagonist has become controversial, because it causes akathisia and extrapyramidal symptoms (EPS). Perospirone is an antipsychotic, believed to exert an antiemetic effect by acting on dopamines, serotonins, and histamine. Perospirone was developed and marketed in Japan in 2001, and has the marked advantages of causing reduced drowsiness, less of weight gain, compared with olanzapine and quetiapine.
Aim: To compare the usefulness of prochlorperazine and perospirone as an antiemetic at the start of oxycodone administration at 10 mg/day at fixed intervals and to evaluate the antiemetic effect of perospirone in animal experiments.
Methods: A retrospective study was conducted of in- and outpatients at our hospital's Department of Palliative Care. Medical charts were reviewed for patient profiles, the presence or absence of nausea within 1 week and of EPS during the period of antiemetic administration. In addition, the antiemetic effects of prochlorperazine and perospirone were evaluated in ferrets.
Results: The rate of nausea within 1 week in the prochlorperazine group was 6.8%, which was not significantly different from that (5.1%) in the perospirone group. The two groups showed no significant difference either in the presence or absence of nausea after the oxycodone dose increase or in the oxycodone dose causing nausea. Moreover, prochlorperazine induced EPS within 1 week in all patients, and the main symptom was akathisia. Further, there was no significant difference in the duration of antiemetic administration. In the animal experiments, pretreatment with perospirone significantly inhibited morphine-induced nausea and vomiting.
Conclusion: The results suggest the usefulness of perospirone in the prevention of nausea at the time of opioid therapy introduction.

PE 2.S436

Evaluation of the clinical effectiveness of physiotherapeutic management of lymphatic oedema in palliative care patients

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Aim: Physiotherapy has an important role in the assessment and management of multiple symptoms in palliative medicine. The role of the physiotherapist, as an essential member of the multi-disciplinary team in palliative medicine is one of the keys to successful rehabilitation and management of patients with cancer and non-malignant motoneuron disease such as ALS and palliative care needs. The aim of the present study was to evaluate the frequency and effect of physiotherapeutic interventions in palliative patients with lymphatic oedema.
Methods: In a retrospective study data of the 208 patients admitted to our palliative care unit from January 1, 2007 to December 1, 2007 were evaluated. Demographic and cancer-related data, such as diagnosis, symptoms, Karnofsky performance status, effect of physiotherapeutic interventions were documented and compared. Statistics: mean±SD, median.
Results: Of the 208 patients 90 that reported symptom load due to lymphatic oedema were included; 67 (74.4%) had pain, 23 (25.5%) dyspnoea due to progredient trunk oedema. Mean age 65.5±13.0 years; 33 (36.7%) male; Karnofsky Index 50% (30-80%), mean length of stay 15.6±8.0 days. Number of physiotherapeutic treatment interventions during the duration of stay was in mean 7.0±5.8. Manual lymphatic drainage was well tolerated in 83 (92.2%) patients; 63 of 67 (94.0%) patients showed a clinically relevant improvement in pain, and 17 of 23 (73.9%) in dyspnoea.
Conclusions: The majority of the patients showed a clinically improvement in the intensity of symptoms

after manual lymphatic drainage. Adjuvant physiotherapeutic interventions for symptom management are an essential part in end-of-life care of palliative patients.

PE 2.S437

How good is our guess? Contrasting views of factors influencing decision on cardiopulmonary resuscitation in palliative care patients and oncological staff members

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Aim: Discussion about cardiopulmonary resuscitation (CPR) might be avoided by many physicians in palliative care patients and physicians trend to underestimate patients´ quality of life. We aimed to find out whether influencing factors on palliative care patients´ decision on CPR exist and whether there is accordance with the employees´ estimation.
Methods: Patients from our Palliative Care Unit underwent a structured interview. Attitudes regarding decline of CPR were asked, as well as risk factors (RFs), which were assumed to influence this decision. Employees from our Department, who were unaware of the results evaluated these RFs and estimated them regarding their impact on the patients´ decision. Employees´ answers were reviewed with respect to the patients´ answers. For statistical analysis Chi-square tests was applied.
Results: From 01/2002 until 01/2006 288 patients (168 female/ 120 male, mean age 72yrs.) were enrolled. 130 patients (45.1%) refused CPR, regarding the RFs, there were no statistically significant differences between patients who refused CPR and patients who did not. However, there was a trend towards dyspnoe [22% vs. 13.6%, odds ratio: 1.79, 95% confidence interval: 0.96-3.34].
Employees overestimated the prevalence (prev.) of most of the RFs [(prev. (%) in employees vs. prev. (%) in patients who refused CPR, p-value (p)): age: 72.5 vs. 50.8, p: 0.02; pain: 77.1 vs. 40.9, p: < 0.01; nausea 46.7 vs. 18.8, p: < 0.01; dyspnoea 63.6 vs. 22.0, p: < 0.01; immobility 59.5 vs. 28.2, p: < 0.01; physical limitation 78.7 vs. 68.4, p: 0.25; cognitive limitation 94.3 vs. 64.3, p: < 0.01] and underestimated the impact of weakness, living alone and need for help at personal hygiene [54.8 vs. 78.0, p: < 0.01; 39.4 vs. 73.9, p: < 0.01 and 20.0 vs. 54.0, p: < 0.01].
Conclusions: We detect no RFs on palliative care patients´ decision on CPR. Apart from appraisal of physical limitation, there was no accordance with the employees´ estimation.

PE 2.S438

The effect of octenisept and hydrocolloid dressings on bacterial flora in pressure ulcers of patients with advanced cancer

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Introduction: We present a small pilot study assessing the effect of Octenisept used with hydrocolloids on the bacterial flora and clinical changes of pressure ulcers in patients with advanced cancer.
Method: During 2006/07 we recruited 45 pts with advanced cancer and p. ulcers into the study. At baseline and at the end of the 4-week study period we assessed ulcer: % of necrotic, granulation tissue and exudate, oedema and/or erythema of the surrounding skin; undermining/pockets, pain, microbiological samples from wound were swabbed after dressing removal. An Octenisept-soaked compress was then applied for 1 min, after which it was removed. Next, hydrocolloid dressings (Granuflex, ConvaTec) were applied. The same nurse team performed the dressing changes in sterile conditions. Swabs were incubated for 24-48 hours at 37°C and inoculated by isolation method onto media enriched with 5% sheep blood and onto selective-differentiating media.
Results: Baseline assessment: All of the wounds contained both Gram+ and Gram- bacterial strains. E. faecalis was the most frequently isolated organism (22%), and was present mainly in sacral, coccygeal, ischial and buttock ulcers. The prevailing Gram- were E. coli (12%) and P. mirabilis (14%).
Assessment after 4 weeks in 43 pts shown a sign. reduction in the number of bacterial species. In all pts S. aureus and S. epidermidis were eradicated. In 3 pts E. faecalis persisted. Gram- bacteria were also eradicated, but in one patient E. coli persisted. None of the pts developed any clinical signs of infection.
Conclusion: These preliminary findings suggest that Octenisept may be an effective and can play a positive role in the treatment of p.ulcers. However, controlled trials are needed to assess its effect, especially when used in combination with hydrocolloids or other modern wound dressings. Octenisept also needs to be compared with other products that claim antibacterial properties on other types of chronic wounds.

PE 2.S439

COPD, metastatic breast cancer and pain - A challenge!

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Introduction: Although the majority of palliative care patients suffer from cancer, patients with non malignant diseases also require palliation of their symptoms.
Method: We present the case of a 58 year old woman with breast cancer and extensive bone metastasis who was admitted for alleviation of pain. Beside her malignancy she suffered from COPD grade IV, with global respiratory insufficiency and BIPAP home ventilation.
After opiate rotation and broad coanalgetic therapy the pain decreased from 9-3 on the VAS scale.
Due to respiratory distress and anxiety we startet with low dose benzodiazepines. The patient developed a live threatening respiratory failure with pCO2 levels of 70mmHg. Although a ventilation therapy was strictly rejected by the patient at this time a mask ventilation with her own BIPAP maschine was started . After normalisation of blood gases the woman articulated, that it was her clear intention ro receive live prolonging treatment, assisted ventilation and resusciation at any time.
Discussion: COPD patients require special experience due to their impaired respiratory capacity, anxiety and repeated episodes of severe dyspnoea. Statements under raised pCO2 levels should not be misinterpreted as the true intention of the patient. This case demonstrates how important it is to discuss questions concerning life prolonging procedures and resuscitation in advanve.
Conclusion: COPD patients are an increasing challenge for palliative care units. They require special skills and attention due to their impaired respiratory situation.

PE 2.S440

How common is COPD among palliative care patients? A retrospective survey

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Introduction: Most patients who are admitted to palliative care units suffer from cancer, but there is an increasing number of cases with non malignant diseases like end stage CCF, COPD or renal failure.
Method: We retrospectiively evaluated all admissions to our palliative care unit (10 beds) during the period from April 2007 till March 2008. Patients were divided into malignant and non-malignant disease. A special focus was put on the group of COPD patients.
From 166 patients, 136 cases (81,9%) had a malignant disease, 30 patients (18,1%) had a non malignant illness like chronic pain syndrome (13 pat.) or cirrhosis of the liver (6 pat.) Only 4 patients (2,4%) had COPD without malignant disease. 11 tumor patients had malignancy and COPD.
In addition we looked at the number of patients who required inhalation therapy with steroids and ?2-sympathomimetics: 47 patients (28,3%) needed an inhalation therapy, but only 15 patients (9,5%) had a diagnosed COPD. Most of those patients, who need an inhalation-therapy also had nicotin abusus in their history and suffered from a bronchial carcinoma (15 pat.) or pulmonary metastasis (4 pat.).
Discussion: Patients with non-malignant disease are still a minority. Although their prognosis is poor the are often admitted to acute medical wards.
The diagnosis of COPD is common among lung cancer patients, but still underdiagnosed. Due to their impaired lung function, anxiety and respiratory distress they require special attention. In addition they are often malnourished because of their increased respiratory working load.
The evaluation of special needs of this group of patients will be the aim of a prospective study.
Conclusion: Only 18,1% of palliative care patients suffer from non malignant disease. Especially COPD patients are an increasing challenge for palliative care units as they require special attention due to their impaired respiratory situation.

PE 2.S441

Fatigue and its potential correlates anemia and depression: Prevalence, changes over time and associations in outpatients with lymphomas, lung, breast, or colorectal cancer receiving chemotherapy

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Aims: Describe
1) prevalence of fatigue, other anemia-related symptoms, and depression,
2) changes of symptoms over three months,
3) associations between fatigue, anemia, depression, concurrent symptoms, clinical and demographic variables in outpatients with lymphomas, lung, breast, or colorectal cancer receiving chemotherapy in a Swiss oncology clinic.
Methods: Prospective study; data were collected at start of chemotherapy (T1), one week prior to the third (T2) and fourth (T3) cycle. The convenience sample included adults starting chemotherapy irrespective of stage of disease, expected to survive over three months. Symptoms were measured with the Fatigue and Anemia Additional Concerns Scales of the Functional Assessment of Chronic Illness Therapy Measurement System, the Hospital Anxiety and Depression Scale, and the Memorial Symptom Assessment Scale. Data were analysed using descriptive statistics, Pearson correlation coefficients, multiple regression and, for longitudinal data, random-intercept regression.
Results: At T1, T2 and T3, 77 respectively 58 and 53 patients participated. At T1, patients indicated the following scores (mean ± SD; possible range): fatigue 36.3 ± 12.4 (0-52), anemia additional concerns 20.6 ± 4.7 (0-28), depression 5.0 ± 4.0 (0-21), anxiety 5.6 ± 3.8 (0-21). Anemia (Hb < 12 g/dL) was present in 39% at T2 and 49% at T3. At T2 and T3, fatigue and other anemia-related symptoms had increased. Fatigue varied greatly within and among patients; patients with higher depression scores reported more fatigue. Performance status and depression explained 60% of the variance in fatigue at T2.
Conclusions: Fatigue varied widely but was already common at the start of and increased during chemotherapy, with depression as predictor. Thus, a systematic assessment of both symptoms seems required, followed by individual care plans that include adequate causal and symptomatic treatments. Funding was mainly provided by the Swiss Cancer League.

PE 2.S443

Symptoms and quality of life: A cross-sectional, descriptive, correlation study, evaluating the relationship between symptoms and quality of life in cancer patients on opioids

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The goal of this study, which was a part of a larger international study, the European Pharmacogenetic Opioid Study (EPOS), was to assess the symptomatology of cancer patients on opioids and to explore the relationship between symptoms and quality of life (QOL).
The research design was descriptive, cross-sectional, and correlational. The variables were symptoms and a global health/QOL score. Descriptive statistics were used to describe the symptomatology and QOL score and inferential statistics were used to test the difference between variables Multiple linear regression was used to model the association between variables. Participants were 150 cancer patients on opioids, 62 (41%) men and 88 (59%) women, all Caucasians. The patients ranged

in age from 20-92 years with a mean (SD) age of 64,7 (12,7) years.
The mean (SD) number of symptoms in the past 24 hours was 6,2 (2,5), and 9,0 (3,3) in the past week. The most common symptoms were fatigue, pain, and weakness. Mean (SD) symptom severity was 0,7 (0,4) in the past 24 hours and 0,9 (0,5) in the past week on a scale from 0-3. Gender and concurrent diseases were not related to number of symptoms, symptom severity or QOL, but increased age was associated with fewer symptoms and less symptom severity, although age difference was not found for global health/QOL score. Adjusted for age and gender, number of symptoms explained 25,8% of the variance in global health/QOL. Also adjusting for age and gender, pain, fatigue, insomnia, and depression explained 33,6% of the variance in global health/QOL.
The findings in this study are similar to what has been reported elsewhere. Number of symptoms and the individual symptoms of pain and notably fatigue were associated with diminished QOL. Surprisingly insomnia and depression did not add significantly to the regression model. These results indicate that QOL of cancer patients may be improved by assessing and treating cancer related symptoms.

PE 2.S444

Domiciliary intravenous continuous drug infusions in the management of advanced chronic heart failure in elderly population

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Introduction: End-stage chronic heart failure (ESCHF) is very common in the elderly population, and often requires multiple hospitalizations for acute decompensations, with risk for nosocomial complications and psychological disturbances for patients and relatives. Therapeutic management of ESCHF may include intravenous drug perfusions. Usually, these treatments force a hospital admission, but the existence of a Hospital at Home Unit (HHU) permits an alternative approach for the management of these patients.
Objectives: To analyze the clinical evolution of a series of ESCHF-patients admitted in the HHU for continuous intravenous treatments at home.
Results: 9 patients (5 men and 4 women), which generated 16 episodes in HHU. Mean age was 84 years (range 76-90), and all maintained a good cognitive status at admission. They came from the Heart Failure Unit where they were diagnosed of decompensated ESCHF despite an optimized oral treatment. All of them had required at least 1 hospitalization in the previous 6 months (range 1-3). Patients were treated during a mean period of 9 days (range 1-22) with dobutamine (1), dopamine at pre-beta doses (5), both agents (5), furosemide (4), and morphine (1). 2 patients subsequently received perfusion of morphine than became necessary because of the lack of response to the initial treatment. These last 3 patients died comfortably and supported by their relatives. The rest 6 patients improved and were discharged with a complete satisfaction with the attendance of HHU. They are alive with a mean follow-up of 4 months (range 0.5-14m). No adverse events were related to the treatments.
Conclusion: Administration of continuous intravenous drugs at home in some ESCHF-patients is safe and permits an alternative to the conventional hospitalization, appreciated by patients and relatives.

PE 2.S445

Asthenia intensity and factors related (consumption of some drugs, anemia, malnutrition and hepatic failure)

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Background: Asthenia is one of the most prevalent symptoms in terminally ill patients. It´s a multifactorial symptom.
Aim: Professionals´ palliative care team of Extremadura (Llerena-Zafra) have designed a study to assess the intensity and factors associated with asthenia in connection with medication and analytical data.
Methods: Retrospective, observational descriptive study.
A review of the medical files of patients admitted to the program between January and June 2008 was made. Inclusion criteria: Patients with asthenia equal to or greater than 6, valued by professionals with a visual analogic scale (VAS 0-10).
Variables to study:
• Analytical data of the patient: hemoglobin, albumin / protein and transaminase as markers of anemia, malnutrition and hepatic failure respectively.
• Use of opioids, antihistamine drugs, antiemetic drugs, benzodiazepines and neuroleptics.
The data were analyzed by frequency distribution.
Results: 86 medical files were reviewed. 55 patients (62.5%) had asthenia. 29 (52.7%) were with opioids, 4 (7.2%) antihistamines drugs, 17 (30.9%) antiemetics drugs, 34 (61.8%) benzoiacepines and 10 (18.2%) neuroleptics. The data are represented in the table1.
Table 1. Number of patients with ≥ 6 asthenia and its relation to the consumption of some drugs and analytical data.

	VAS Asthenia	6	7	8	9	10
Number of patients	Opioids	8 (61%)	8 (47,05%)	7 (38,8%)	4 (100%)	2 (66,6%)
	Antihistamine	1 (7,6%)	1 (5,88%)	1 (5,55%)		1 (33,3%)
	Antiemetic	3 (23%)	4 (23,52%)	5 (27,7%)	3 (75%)	2 (66,6%)
	Benzodiacepine	**6 (46,15%)**	**11 (64,70%)**	**10 (55,5%)**	**4 (100%)**	**1 (33,3%)**
	Neuroleptic	1 (7,6%)	1 (5,88%)	8 (44,4%)		3 (100%)
	Hb	**7 (53,8%)**	**2 (11,76%)**	**6 (33,3%)**	**1 (25%)**	
	Prot-AL	4 (30,7%)		2 (11,11%)	1 (25%)	
	Bt/Trans	2 (15,2%)	1 (5,88%)	1 (5,55%)	2 (50%)	
	Sample	13 (23,63%)	17 (30,90%)	18 (32,72%)	4 (7,27%)	3 (5,45%)

Conclusion: Within the sample, 62.5% presented asthenia. Treatment with benzodiazepine is the most used by more than 50% of cases, which makes us think is a factor in relation with the presence of asthenia. Referring to analytical data, anemia is the most prevalent factor associated with asthenia.

PE 2.S446

Fatigue and its potential correlates anemia and depression: Prevalence, changes over time and associations in hospitalized patients with advanced cancer

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Aims: Describe
1) prevalence of fatigue, other anemia-related symptoms, and depression,
2) changes of symptoms over ten days,
3) associations between fatigue, anemia, depression, concurrent symptoms, clinical and demographic variables in patients with advanced cancer admitted to two Swiss tertiary care hospitals.
Methods: Prospective study; data collection at admission (T1) and on day six (T2) and ten (T3). The convenience sample included adults admitted because of new and/or worsening symptoms, or general deterioration of health status, or any complications. Symptoms were measured with the Fatigue and Anemia Additional Concerns Scales of the Functional Assessment of Chronic Illness Therapy Measurement System, the Hospital Anxiety and Depression Scale, and the Memorial Symptom Assessment Scale. Data were analysed using descriptive statistics, multiple regression and, for longitudinal data, random-intercept regression.
Results: At T1, T2 and T3, 103 respectively 76 and 53 patients participated. At T1, patients indicated the following scores (mean ± SD; possible range): fatigue 23.5 ± 13.4 (0-52), anemia additional concerns 17.5 ± 4.6 (0-28), depression 7.8 ±5.3 (0-21), anxiety 6.3 ± 4.5 (0-21). Anemia (Hb < 12 g/dL) was present in 62%. Fatigue varied greatly within and among patients; patients with higher depression scores reported more fatigue. Over time, fatigue decreased for patients who improved and were discharged ($p < .0001$) but not for those with worsening health status. Performance status, age, depression, other anemia related symptoms, and the number of concurrent symptoms explained 64% of the variance in fatigue at T1.
Conclusions: Fatigue was common but varied widely in these hospitalized patients. Thus, a systematic assessment at admission seems required, followed by care plans that are adjusted to individual patient situations and include causal and symptomatic treatments if adequate.
Funding was mainly provided by the Swiss Cancer League.

PE 2.S447

Topical application of a beclometasone aerosol inhaler for the treatment of peristomal inflammation

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Bowel stoma formation is a common procedure as part of either palliation or cure for a range of intra abdominal or pelvic malignancies. Occasionally inflammation can occur around the stoma site leading to discomfort and poor adhesion of the stoma bag. Simple measures can reduce this, such as regular cleaning with gentle drying and barrier film sprays, for example, cavilon.
We describe two cases of stoma site inflammation which did not respond to basic measures of gentle cleansing and barrier film sprays. This resulted in a cycle of inflammation (pain, pruritis with excoriation) with decreased stoma bag adhesiveness and faecal leaking further increasing the inflammation. In both situations a beclometasone steroid aerosol inhaler was sprayed onto the inflamed skin surrounding the stoma site. Within a few days the inflammation had settled with improvement of symptoms and good adhesion of the stoma bag. In one case occasional recurrent inflammation was quickly relieved by a repeat course of steroid inhaler application.
The rationale for using a dermally applied corticosteroid is to reduce inflammation without the compromise of stoma bag adhesion that occurs with creams or lotions. We have shown that a steroid dry powder aerosol inhaler sprayed topically on the peri-stomal skin can be effective for resistant stoma site inflammation, without compromising the adhesion of the stoma bag.
We recommend controlled trials of steroid inhalers in situations needing a topical steroid to reduce inflammation when the skin needs to remain dry as to not compromise adhesion of a stoma bag.
Funding for this project was provided by the local hospital.

PE 2.S448

Management of refractory emesis in a patient with a carcinoid tumour using Aprepitant - A neurokinin-1 receptor antagonist

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Carcinoid tumours originate from the enterochromaffin cells in the neuroendocrine system. They secrete a large number of biologically active amines and peptides, including serotonin, bradykinin, tachykinins (substance P and neuropeptide K), histamine, prostaglandins and catecholamines. These are thought to be responsible for the symptoms (which include flushing, diarrhoea and nausea) caused by these tumours.
The two main mediators secreted by these tumours which cause emesis are serotonin and substance P (SP). Serotonin is a 5- hydroxytryptamine (5HT) receptor agonist and SP activates the neurokinin 1 (NK 1) receptor. The setrons, including ondansetron and granisetron, which block the 5HT3 receptor may only be partially effective for emesis in this condition. Aprepitant, a NK 1 receptor antagonist, has been shown to be effective in reducing delayed nausea and vomiting in highly emetogenic chemotherapy. It also has a pathophysiological basis for reducing emesis caused by carcinoid tumours. We describe a female patient with a small bowel carcinoid tumour with severe emesis resistant to the commonly used antiemetics, including ondansetron, levomepromazine, and metoclopramide. She had a dramatic resolution of her symptoms after we prescribed a three day course of aprepitant. On stopping the aprepitant she remained asymptomatic for

10 days, at which point her emesis returned. A further 3 day trial of aprepitant led to a complete improvement in her symptoms. The aprepitant was continued, as mono-antiemetic therapy, until she died two months later, without further recurrence of her nausea or vomiting.
In view of this patient's rapid and complete response to aprepitant, without any side effects over the 2 month treatment period, we suggest that this NK1 receptor antagonist could be used in patients with carcinoid induced emesis resistant to traditional therapy. Controlled research is necessary to confirm this novel finding.
Funding provided by local hospital.

PE 2.S449

A bone of contention: Bisphosphonates in the management of metastatic bone disease

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Aim: Metastatic bone disease is common in cancer patients and can cause substantial morbidity. The use of bisphosphonates is recognised to reduce the severity of skeletal complications in some tumour groups and also improve pain control. However the magnitude of benefit, who to treat, when to treat and for how long remains unclear. We aimed to explore the prescribing of bisphosphonates across the Merseyside and Cheshire Cancer Network (MCCN) in the UK.
Methods:
1. A proforma was developed to audit prospectively the use of bisphosphonates(excluding treatment for hypercalcaemia) over a 6 month period in 3 Integrated Clinical Networks (ICN´s) of MCCN including community, hospital and hospice settings.
2. A separate questionnaire was distributed to all specialist palliative care teams via the ICN chairs to establish practice across the MCCN. This focused on patient selection criteria,choice of bisphosphonate,awareness of adverse effects and assessment of response. These questionnaires were also sent to oncologists,urologists and haematologists and these results were analysed separately for comparison.
Results: Preliminary results indicate that zolendronic acid was the most commonly used bisphosphonate, particularly in the hospice setting. Differences were also highlighted in patient selection criteria and there was a wide variation in the assessment of response.
Conclusion: The audit identified a lack of good information provision for patients receiving bisphosphonates from palliative care teams. The need for policies, especially regarding calcium supplementation and dental issues is highlighted. There also appeared to be a lack of understanding of some of the potential risks of treatment amongst the palliative care responses. The need for further research in this area is recognised and the MCCN guidelines and standards for the use of bisphosphonates in metastatic bone disease have been revised following a current review of the literature and the audit findings.

PE 2.S450

Use of morphine to control teminal dyspnea in a palliative care unit in Brazil

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Background: The dyspnea is defined as: "Feeling uncomfortable in the act of breathing" and is one of the most prevalent and devastating symptoms in patients with advanced cancer, independent of the primary site of the disease. It one of refractory symptoms most commonly associated with the progressive loss in quality of life About 70% of patients with advanced cancer present some degree of dyspnea in the last six weeks of life. The Morphine is one of the best medicines for the treatment of terminal dyspnea, it reduces the discomfort and increases the tolerance to hypoxia and hypercapnia.
Objectives: To evaluate the incidence of dyspnea in hospitalization patients, the most prevalent disease and the use of morphine as medication of choice.
Materials and methods: Retrospective analysis of patient records. Were evaluated 78.9% of 119 deaths in the hospital in July 2007, all randomly selected.
Results: We found 55 patients (57.8%) that had dyspnea in the last 48 hours of life. Of these, 67.92% (n = 36) have made use of morphine in the same period, against 32% (n = 17) subjected to other medications. We find that 31.5% of patients (n = 30) had dyspnea as the main reason for hospitalization and 70% (n = 21) of these have made use of morphine. The pathology more related to dyspnea, in population that is transferred by the symptom or in population that showed during hospitalization, was the cancer of the lung (25% and 32% respectively), followed by cancer of the breast (18% and 22% respectively). Of the patients who admitted for dyspnea 53% (n = 16) had survival of 1 to 5 days and only 7% (n = 2) had higher survival than 10 days.
Conclusion: Although dyspnea is a symptom of the most prevalent and morphine is the drug of choice to treat it in patients with advanced cancer, we can see that 30% of patients whose main reason for hospitalization was dyspnea did not use the same until death. In our service we carry out research and protocols to improve their approach.

PE 2.S451

What is the cancer anorexia cachexia syndrome?

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Aims: There is no unified definition of cachexia, and even less of the cancer anorexia-cachexia syndrome (CACS). This hinders research efforts. To answer: "What is CACS?", a historical overview of cachexia descriptions was conducted. Modern definitions were analyzed. A definition is suggested.
Methods: Web-based searches of key words "cachexia" or "wasting" in: "books.google.com" (which allowed download of old textbooks and search of their content), library online catalog at Cleveland Clinic. Tables of contents and indexes of major relevant textbooks were searched manually.
Discussion: Historical descriptions (from King David to Hippocrates), to later description by many eminent physicians reveal:
(a) cachexia has been known since ancient times, as a severe constitutional manifestation of many illnesses;
(b) it has always been distinguished from starvation;
(c) reduced body weight and anemia are an integral part of the definition in both old and new descriptions;
(d) the inevitable outcome (i.e. death) is long acknowledged;
(e) new descriptions have not significantly expanded the definition;
(f) cachexia was a clinical diagnosis of severe emaciation. This has evolved to include body compartments analysis;
(g) Cachexia induces both muscle and fat wasting, unlike starvation where it is mostly limited to fat. Cachexia is dynamic process. Established cancer cachexia is easily recognized. In contrast early wasting is hard to diagnose without established clinical or biochemical criteria. Once established, cachexia cannot be reversed. Early diagnostic markers are needed.
Conclusions: Important descriptors that ought to be part of CACS definition:
(1) "cachexia" refers to the emaciated patient.
(2) CACS is not a stage but a process.
(3) Unlike starvation, CACS does not respond to nutritional support.
A uniform definition is needed.

PE 2.S452

Last week of life: Symptoms and treatment of neoplastic patients in home care

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The main objective of palliative care is the highest quality of life possible throughout the entire period of assistance to the patient, and in particular during the last days of life when the physical symptoms, often multiple, can increase in intensity, proving more difficult to treat and extremely invalidating for the patient. The aim of this study was to evaluate the predominance of symptoms in the last week of life of patients suffering from cancer in an advanced phase, followed in home care by our palliative care team, and the therapeutic strategy undertaken to treat those symptoms.
Materials and methods: The medical records of 192 patients who died during the year 2007 amongst the 265 who were followed in home care in that year, in the District of Merate (LC). For each patient the symptoms present in the last week of life were registered, calculating the prevalence of: the drug/s used for the treatment of each symptom, the average daily dosage for the treatment of each symptom and the eventual efficacy of the treatment itself.
Results: The most frequent symptoms in the last seven days of our patients were the following: pain (96%), agitation (76.2 %), death-rattle (50%), dyspnoea (20%), vomiting (20%). From a preliminary analysis of the data, the control of the majority of the symptoms appears to have been good, with the therapeutic strategies adopted. Our work emphasizes that, with an expert team, the satisfactory management of multiple problems in home care is possible.

PE 2.S453

Levodropropizine in the management of cough associated with cancer or non-malignant chronic disease - A limited systematic review

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Aim: Cough associated with cancer or non-malignant chronic disease is common and can be very distressing. Levodropropizine (L), a peripherally acting drug, has been used to relieve cough in these patients as an alternative to opioids. We therefore aimed to determine the efficacy and safety of L in relieving cough associated with cancer or non-malignant chronic disease.
Methods: We searched Medline, Embase and the Cochrane library as well as handsearched relevant journals and textbooks to identify randomised controlled trials and quasi-experimental studies assessing the antitussive effect of L in the above defined patient population. The quality of identified studies was assessed using a modified version of the Centre for Reviews and Dissemination (CRD) criteria.
Results: The search yielded a total of 35 references. Of these, 6 were checked in more detail, and finally, 4 studies published in 3 papers were included. Altogether they included 324 patients. Two were randomised controlled trials testing L against Dihydrocodeine and Moguisteine respectively, and two were non-randomised placebo-controlled studies, all with important limitations and high risk of bias. L was significantly more effective than placebo in reducing cough frequency and severity, and equally effective as Dihydrocodeine or Moguisteine. It was generally well tolerated. Due to the differences between primary studies regarding populations, control intervention and outcome measures, meta-analysis was impossible.
Conclusion: The evidence for the efficacy of Levodropropizine for the management of cough in patients associated with cancer or non-malignant chronic disease is scarce, and is further limited by the methodological weaknesses of the primary studies. It might be used as an alternative drug for opioid-resistant cough, but further well-designed research is needed to support this strategy.

PE 2.S454

Palliative sedation in a palliative care unit: Experience and new prospects

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Introduction: The palliative sedation is the most appropriate treatment for patients with refractory symptoms of a disease in progress. It is a way to provide comfort to patients and their families, without, however precipitate death (principle of double effect).
Objective: To evaluate the profile of patients undergoing Palliative Sedation in the year 2007, regarding the frequency and cause of the indication of the procedure, the drugs most used, duration of survival and present new perspectives in technology and pharmacology.

Materials and methods: Retrospective analysis of records of patients who underwent the palliative sedation during the last admission at our unit in the year 2007.
Results: There were 36 patients in total sedation in the period, with an average of 1.75% per month (in relation to the number sedated patients throughout the year). The most prevalent symptom was dyspnea, followed by delirium. The medicine used for sedation was the midazolam, followed by a combination of morphine with midazolam (both in pump infusion). The majority of patients progressed to death in up to 48h, and that the maximum survival was 20 days. The symptom with the lowest average survival was dyspnea, with an average of 1.77 days. During the year 2007, it was found that only 1 of 36 patients sedated with midazolam presented great difficulty to achieve satisfactory level of sedation. None of the patients had the sedation reversed.
Conclusion: Currently term use of free and informed consent to obtain authorization from the patient and when it is no longer possible, the family or guardian; from 2008. In 2008, the possibility of introducing the drug propofol to the arsenal in order to determine what would be the gold standard for drug concerned Palliative sedation, but Midazolam remained as the standard, according to the technical difficulties of use of propofol for long periods. Studied, even if the adoption of the BIS as a tool for assessing the level of sedation.

PE 2.S455

Pressure ulcers' prevention and care: Nurses' knowledge

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Aim of the research: To assess nurses'knowledge in pressure ulcers'prevention.
Objectives:
- To analyze nurses' knowledge in pressure ulcers' prevention.
- To assess nurses' knowledge in care of patient with pressure ulcers.
- To compare nurses' knowledge in pressure ulcers' prevention and care of patients with pressure ulcers among nurses.
Respondents: Nurses, working with patients with pressure ulcers or risk of them. 76 nurses were investigated. Research was done during January-February of 2008 year in 3 Kaunas hospitals by anonymous questionnaire test, created by authors.
Results: Mostly of nurses know about reasons of pressure ulcers (82 percent), importance of prevention of pressure ulcers, proper means for prevention; can recognize early signs of pressure ulcers (72 percent). Nurses know what actions are needed in care of pressure ulcers and what means quicken healing of pressure ulcer (removal of pressure into ulcer, change of position, appropriate skin care). Nurses sometimes use inappropriate (old) means for prevention of pressure ulcers. Pressure ulcers' risk scales are not used regularly. Nurses in nursing hospitals use risk scales for pressure ulcers more than nurses in university hospital (41,7 percent and 2,5 percent).
Conclusion: Nurses' knowledge in pressure ulcers' prevention and care is insufficient.

PE 2.S456

Inoperable malignant bowel obstruction in advance cancer patients: Predictive factors of no spontaneous resolution

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Introduction: Malignant bowel obstruction (MBO) is a common complication in advanced cancer patients (3-15%). Conservative medical treatment can achieved 80% of symptom control and spontaneous resolution is observed in 30% of cases. Predictive factors of spontaneous resolution of MBO are not still known.
Objective: To identify predictive factors of no spontaneous resolution of inoperable MBO.
Method: Cross-over study.
Care setting: Palliative Care Support Team of a University Hospital.
Inclusion criteria: Prospective inclusion of all cancer patients diagnosed of MBO.
Data collection: Structured record including demographic data, cancer diagnosis, extension status, physic symptoms, level of MBO, blood analysis, Karnofsky and Barthel index.
Analysis: Univariate analysis was used to examine the relation between clinical data and probability of no spontaneous resolution of MBO.
Results: 100 MBO episodes were prospectively included (MBO prevalence 11%). No resolution of MBO was observed in 58% of cases. In stratified data comparing both groups of patients (resolution versus no resolution) no statistic differences were found in univariate analysis for gender, MBO previous episodes, obstruction level, peritoneal carcinomatosis, anemia, hyponatremia, hypoalbuminemia, ascitis, symptom severity and hepatic or renal failure. Significant statistical differences were observed in (% of no resolution/ Odds ratio/ IC 95%/ p): cognitive failure (82,6%/ 4,6/1,4-14,9/<0,05); abdominal palpable tumors (81,0%/3,9/1,2-12,7/<0,05); cachexia (86,4%/6,3/1,7-23,1/<0,05); dehydratation (81,8%/4,2/1,3-13,8/<0,05); previous Karnofsky index<70% (74,3%/5,6/4,1-32,7/<0,001); previous Barthel index <70% (80,4/7,7/3,1-19,1/<0,001).
Discussion: In this study, probability of spontaneous resolution of MBO is 42%. The analysis demonstrated that cognitive failure, cachexia, clinical dehydratation, and poor performance and functional status are predictive factors for no spontaneous resolution of MBO.

PE 2.S457

Prevalence and characteristics of lower extremity edema in advanced cancer patients

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Aim: Leg oedema is a commonly encountered symptom in our clinical palliative care practice which significantly impacts patients' physical function, leading to further morbidity, anxiety and feelings of being a burden. Review of the literature provides little specific data on the significance of leg edema in the advanced cancer population. As part of planning a prospective trial of subcutaneous drainage of leg oedema, we investigated the prevalence and clinical aspects of this symptom in the advanced cancer population.
Method: We conducted a chart review of all patients admitted to a tertiary palliative care unit and a hospice unit between January 1 and December 31, 2006. We collected data describing the prevalence and clinical presentation of lower leg edema when documented. We also explored the use of different therapeutic modalities.
Results: This study confirms that this symptom is common in this population. We describe the complications associated with leg oedema. We comment on the under-utilization of the available therapeutic options.
Conclusion: The collected data will contribute to improvement of evidence-based clinical Palliative Care practice, while drawing attention to this often under-appreciated symptom.

PE 2.S458

Clinical indicators of a pressure ulcer and wound tumor of the home care service in a palliative care unit

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Objective: To present the indicators of a pressure ulcer and wound tumor of service home care in palliative care.
Methods: For data collection has created a worksheet to a pressure ulcer and wound tumor that is composed of: identification, date of admission, date of the first assessment, location, staging, exudate, bleeding, odor, treatment, evolution. From that instrument, the results are monthly quantified. Data were collected from July to September 2008.
Results and discussion: The patients average in July was 168, 39 with pressure ulcers: 19 with improvement ulcers, 3 with worsening and 17 retained; 27 injured tumor: 5 showing improvement, 5 kept worsening and 17. In August, the average was 181 patients, 54 with pressure ulcers: 29 with improvement, 5 with worsening and 20 retained; 25 injured tumor: 4 with improvement, 10 with worsening and 11 maintained. In September, the average was 164 patients, 56 with a pressure ulcer: 25 with improvement, 5 with worsening and 26 retained; 36 injured tumor: 7 with improvement, 11 with worsening and 18 maintained. To see improvement or worsening of pressure ulcers was evaluate the stage of ulcers healing and their aspect; in tumor wounds was assessed the degree of odor, exudates, size and bleeding. It is emphasized that a patient may even contain more than a wound or ulcer. After evaluating the results, the team discussed with the intervention of guidelines from the data obtained, such as: implementation of educational work ahead systematic care provided by caregivers/family at home, change of conduct and clinical therapy for improvement of assistance.
Conclusions: With this study, we can say that the use of indicator is a method that helps to improve the quality of care, offers the professional a clear and concise way to evaluate their conduct through the results, providing a clinical and educational work in a unified action, where the exchange of information and views make the work more efficient and secure.

PE 2.S459

A protocol for the control of agitation

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Aim: Agitation occurs frequently in palliative care and is one of the more important reasons for sedation. Agitation can have many causes and can be reversible, but when it occurs can be very distressing for all involved such as family, health professionals and patients and can even put them in danger. Therefore, it is mandatory to control the situation in an effective and quick way, but with a minimum of risk to the patients.
Methods: With this aim in mind a protocol for agitation control was developed; the protocol was activated in 18/06/2007, which was the data of the opening of our palliative care unit (PCU).
Protocol for the control of agitation:
- Haloperidol - 5mg IM + Midazolam - 5 mg IM
30 minutes later, if the situation was not controlled:
- Haloperidol - 2 mg SC + Midazolam - 5 mg SC; up to 2 doses (30 minutes interval)
30 minutes later, if the situation was not controlled:
- Midazolam 5 mg SC every hour till the control of the situation.
If the agitations recurs:
- Less than 2 hours after control: resume the protocol from the interruption point.
- More than 2 hours later: restart the protocol from the beginning.
Results: Until 15/09/2008, 142 patients were admitted and the protocol was used in 11 (8%). 7 (64%) were males and 4 (36%) females and median age was 68 years (56 to 85 years). The protocol was used correctly 42 times, from 1 to 12 times in each patient, median 3 times. The interval between the first dose and the control of agitation was from 5 to 75 minutes, median 22.5 minutes. 69% were controlled in ≤ 30 minutes and 95% in ≤ 60 minutes.
33 (79%) of the agitation episodes were controlled with only the first dose of the protocol, 9 (21%) needed a second dose and only 1 (2%) needed the third. There were not any treatment complications.
Conclusion: The protocol for the control of agitation developed in our PCU is very effective as demonstrated by the quick control of the situation, usually with only one dose, and the lack of complications.

PE 2.S460

Recent clinical trials in cancer cachexia: Systematic literature review on inclusion criteria, endpoints and standard anti-cachexia interventions

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Aim: The classification of cancer cachexia (CC) is evolving towards distinguishable, mechanism-associated cachexia domains, concepts of standard basic cachexia interventions are maturing, and endpoints for clinical trials beyond mere body weight changes are

demanded. To systematically review current CC clinical trial designs.
Methods: Medical databases (PubMed, Cochrane, Embase, PsycINFO, Cinahl) were searched with 2 combined search strings (cachexia, cancer), restricted to English & German, to 15.10.2004 to 15.3.2008 and to clinical trials; abstracts (2005-2007; ASCO, ESMO, MASCC, Cachexia Conferences) with key words (cachexia, anorexia, weight loss) and handsearch (clinical trials), and clinical trials databases (www.controlled-trials.com/mrct; www.clinicaltrials.gov; www.who.int/ictrp/) with cachexia and anorexia. Data were extracted by 2 investigators.
Results: Of 15 of 363 manuscript citations from databanks, 42 of 65 trials from registries, and 20 abstracts (ASCO 7, ESMO 1, MASCC 7, Cachexia-conferences 5), 59 trials were included after exclusion of duplicates. In a large minority of trials, **inclusion criteria** were restricted to selected tumor types, but without stating reasons (e.g., practical accrual facts, registration arguments, expected cachexia subtypes), 2 trials limited inclusion to cachexia subtypes (hypercatabolic [pulse rate], elevated CRP). Most, but not all, trials defined 1 primary **endpoint**, mostly weight, muscle mass, or appetite, and increasingly - but still rarely - functional outcomes (e.g., muscle strength, overall physical function [n=4]) and mechanism-specific variables (CRP [n=1]; GH [n=2]). Few trials referred specifically to **standard basic CC interventions** (nutritional support [n=5], physical activity interventions [n=2], symptom control standards [n=6]).
Conclusion: Joint efforts are needed to integrate novel CC classifications, mechanism-based outcomes, and best palliative cancer care, into clinical trial designs impacting practice.

PE 2.S461

Sleep disturbance, performance status, depression and pain as predictors of fatigue in cancer patients

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Introduction: Early diagnosis and target treatments may be achieved through the identification of fatigue predictors in cancer patients.
Aim: To identify predictors of fatigue in cancer patients.
Methods: A convenience sample of 586 adult outpatients with gastro-intestinal, gynecological, breast, prostate, respiratory and hematological cancers were recruited from 4 oncology clinics at Sao Paulo (Brazil), from July 2006 to July 2007 (mean age 57±13 years; 61% female; 10±5 years of study). Patients filled out an Identification Profile, revised-Piper Fatigue Scale (0-10; cut score:4), Beck Depression Inventory (0-63; cut score:11), and Karnofsky Scale (0-100; cut score:80%), Pain scale (0-10 cut off:) and Sleep disturbance scale (0-10 cut score:).
Results: Fatigue was referred by 32.8% (n=192) of the patients. Logistic regression analyses revealed that Sleep Disturbance (OR:2.6; 95%CI 1.49-4.51), Performance status (OR:2.1; 95%CI 1.22-3.80), Depression (OR: 1.1; 95%CI 1.08-1.18) and Pain (OR:1.74; 95%CI 0.99-3.02) predicted fatigue. When the four factors (Sleep Disturbance, Poor Performance status, Depression and Pain) were present in concomitance, the probability the patients had fatigue was 55.7%. The concomitance of three factors (Sleep disturbance, Poor Performance Status and Depression) explained 42.0% of fatigue's prevalence. When none of them were present, the probability of fatigue occurrence was only 10.3%.
Conclusions: These results indicated that the predictive factors themselves or combined with others are major predictors of fatigue. It was possible to construct a Fatigue Prediction Table which can be easily applied in clinical oncology practice.

PE 2.S462

Gastroprotection and survival at 30 days in a cohort of oncologic and palliative patients

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Aim: To analise the relationship between the guidelines of gastroprotection and the survival at 30 days in a cohort of oncological and palliative patients.
Methods: 201 patients included from february to may 2008. Data studied: age, gender, main diagnosis, treatment with gastroprotective agents, NSAIDs, risk factors for gastric bleeding (age older than 65 years, on steroids, antiagregants, anticoagulants, previous history of peptic ulcus), follow of the guidelines regarding the use of gastroprotection and mortality at 30 days. The statistical analysis was carried out in three steps; first, an univariant analysis was performed between all the variables regarding mortality at 30 days. Second, the binary logistic regression. Third, patients were classified according to the CHAIDS tree method. Statistical significance was assumed if p<0.0500.
Results: With the univariant analysis, a significant relationship was found between being consedered as palliative (OR: 12,2, IC 95%: 5,9-25,0), treatment with steroids (OR: 2,6, IC 95%: 2,4-4,9), treatment with gastroprotective drugs (OR: 3,6, IC 95%: 1,8-6,9), NSAIDs with any of the risk factors (OR: 2,4, IC 95%: 1,6-2,3) and the diagnosis being lung cancer to have the poorest prognosis (OR: 3,8, IC 95%: 1,8-7,8). In the second steponly three variables were found to be significant: gastroprotection as a protective factor and the lung cancer and being palliative as poor prognosis factors. the third step we defined six different groups with different mortalities.
Conclusion: Taking gastroprotection does not have any significant relationship with mortality ans is related to overtreatment and probably, a more advanced satage of the disease.

PE 2.S463

Effective treatment with methrotrexat and dexamethason in Anti-hu negative paraneoplastic syndrome

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Aims: Paraneoplastic syndroms are very often in cancer patients. We describe a woman with bladder cancer without finding antibodies (Anti hu and Anti-Ma) with cognitive disorder.
Methods: A 68 year old woman suffered from bladder cancer since 2007 with bone metastasis in the entire spine, ilic bone and ribs 6 to 8 on the right side. Treatment was started after TURB with local mitomycin chemotherapy application into the bladder. In order to relief pain, therapy with morphine was started.
After one month she was admitted to the department of neurology and neurophysiology due to a delirium. She showed a misjudgement of situation, perception disorder with hallucinations, she became confused and suggestibility.
The examination of cerebronspinal fluid reveals a mild pleocytosis (11 to 26 white cells), glucose 67 mg/dl and a slightly elevated protein 53,1 mg/dl. Lactat was in normal range. A meningiosis carcinomatosa or tumor cells from the bladder cancer could not found. The MRI shows neither bleeding, circulatory disturbance nor metastasis.
Opioidrotation from morphine to fentanyl was done and tretment with neurolepics was started. Due to a minor resoponce of the treatment, she was admitted to the palliative care unit. The blood test was normal. We could not find Anti-hu (ANNA Typ 1), TA and Ma-antibodies in the serum. Psychological assessment showed limitations in higher cognitive capabilities, e.g. disorientation (time, place), calculation capabilities, delusion and hallucination. The result of 7 with the DemTect® screening instrument supported our diagnosis of dementia. Treatment with dexamethason (16 mg per day) and methrotrexat (7,5 mg) weekly. Within a week of tretment the retesting showed a considerable improvement in orientation (time, space), definite reduction of delusion and hallucination and error-free calculating.
Conclusion: Only in suspicion of a paraneoplastic syndrom, the combination of methrotrexat and dexamethasone is effective.

PE 2.S464

Laxatives profile in patients attended by palliative care units

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Objectives:
1) to establish laxative regime used by the palliative care units of our environment
2) determine the degree of control of this symptom in our population.
Population and methods: A descriptive, multicenter, cross-sectional study through a questionnaire in two cuts (02/10/07 and 23/01/08). Were discussed, among other things, the following variables: intestinal rate (number of bowel movements per week), constipation perceived by the patient, opioid consumption and laxative treatment.
Results: A total of 283 patients. Their average age 71 years, 90% cancer diagnosed, 58% more than a month monitoring by palliative care units. Consume opiates and laxatives 63%.
Feel constipated 45% of patients (127/283) and 19% (54/283) performed 2 or less depositions per week. 39% (41/106) of patients not taking opioids are constipated and 18% (19/106) of the same conduct depositions 2 or less per week. With regard to treatment highlights the disparity of approaches found. Of the patients who used laxatives, 14/178 (8%) only continued rectal treatment (enemas or suppositories), 40 more (24%) combined oral and rectal treatment. Of the 163 patients taking oral laxatives, 133 (82%) were taking only a laxative, 25 (15%) took two and the rest three or more. Of the total number of patients taking laxatives by mouth 65% took lactulose (74% if we add lactitiol), 14% magnesium, 13% senna and 12% polyethylene glycol . Only 17/163, 10%, combined an osmotic laxative with senna.
Conclusions: Opioid consumption is a root cause but not the only one of constipation in palliative care. The lack of consensus in the treatment of constipation could influence their little control.

PE 2.S465

Survey of glycaemia management within a hospice setting

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Background: Diabetes is a significant condition with considerable impact on patient morbidity and mortality but also on consumption of costs within the health economy. Diabetes and its care are not context bound and exist in a variety of settings. This resonates with palliative care in that the care of a patient is guided by clinical need and not condition specific. Assessment and management of diabetes and its' sequalae are central to impeccable holistic care of this patient group.
Aim: To assess the current glycaemic practice within a hospice setting.
Method: Retrospective casenote review of inpatients within a hospice setting within the North West of England.
Results: 35 patients were identified with 38 admission episodes. Patient demographics included age (71 yrs (R 40-86)), length of stay (27 days (R 5-86)), outcome from admission (discharge 21, death 16, 1 transfer) and 82% (n=31) of patients admitted for symptom control. Documentation supported type of diabetes (73%) with only 27% of patients having any reference to previous control. Anticipatory glycaemic planning was only documented in 40% of patients despite significant hyper- and hypoglycaemic episodes (26 in total). Anticipatory prescribing favoured hyper- (n=18) rather than hypoglycaemic episodes (n=3) despite the latter being more frequent (16 vs. 4)
Conclusions: Diabetic care consists of assessment of initial control, ongoing review with changes in medication depending on glycaemic monitoring and all this facilitated by comprehensive documentation. This survey has highlighted the need for a clinical pathway of care for Diabetic patients within a hospice setting. It has also underpinned the importance of clinical governance structures existing to ensure continued improvements in the delivery of patient care.

PE 2.S466

Subcutaneous metylnatrexone in the treatment of constipation in advanced Ill patients undergoing opioid therapy

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Constipation is one of the most common problems within the group of advanced ill patients who undergo opiod therapy.
The aim of our investigation was to study the efficacy of subcutaneous peripheral μ-agonist methylnatrexone at patients of our palliative care unit who developed constipation under opioids.
A group of 12 patients was selected. Selecting criteria: advanced disease, opioid therapy since leastwise 1 month, no defecation for 5 or more days despite laxatives and other stimulating activities (such as enemas). 6 patients received Metylnatrexone in addition to conventional methods while the treatment of the other 6 patients was proceeded with common methods only.
Metylnatrexone was injected once in dosage of 8 mg (0,4 ml) at the patients with the weight under 65 kg and of 12 mg (0,6 ml) - 65 kg and more. If there was no response after the first injection we repeated the injection once more on the next day after the first injection.
In the group who received methylnatrexone 2 patients had defecation within 4 hours after the drug was injected. 1 patient had the bowel movement a day later, 3 hours after the second injection. 3 patients had no defecation despite two injections (on day 1 and 2). In the control group defecation was observed in 1 patient on the day 1 and in 1 patient on the day 2; further two patients had the bowel movement 2 days later under colon irrigation and another two patients had no defecation despite all the conventional procedures.
Conclusions:
1. Subcutaneous Metylnatrexone showed its efficacy in 3 of 6 patients inducing defecation within the first 4 hours after the first injection (in two cases) or the second injection on the next day (1 patient).
2. In the patients where injections of methylnatrexone were not successful, the mechanical bowel obstruction as a supplementary problem to an opioid-induced constipation can be discussed.
3. None of the patients who received Metylnatrexone showed any adverse reactions or side effects.

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Published by **Hayward Medical Communications**,
publishers of the *European Journal of Palliative Care*
a division of Hayward Group Ltd, The Pines, Fordham Road, Newmarket CB8 7LG, UK.

Printed by Latimer Trend, UK

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ABBREVIATED PRESCRIBING INFORMATION
Before prescribing Relistor®▼ please refer to full Summary of Product Characteristics. **Presentation:** Relistor 12 mg/0.6 ml solution for injection. Each vial of 0.6 ml contains 12 mg methylnaltrexone bromide. One ml of solution contains 20 mg methylnaltrexone bromide. For subcutaneous injection. **Uses:** Treatment of opioid-induced constipation in advanced illness patients who are receiving palliative care when response to usual laxative therapy has not been sufficient. **Dosage:** For adults only. Relistor should be added to induce prompt bowel movements when response to usual laxative therapy has not been sufficient. The recommended dose is 8 mg (0.4 ml) (for patients weighing 38-61 kg) or 12 mg (0.6 ml) (for patients weighing 62-114 kg). Patients whose weight falls outside of the ranges quoted should be dosed at 0.15 mg/kg. The recommended administration schedule is one single dose every other day. Doses may also be given with longer intervals, as per clinical need. Patients may receive two consecutive doses 24 hours apart, only when there has been no response (bowel movement) to the dose on the preceding day. ***Renal patients:*** In patients with severe renal impairment (creatinine clearance <30 ml/min), the dose should be reduced to 8 mg (0.4 ml) for those weighing 62-114 kg, and to 0.075 mg/kg for those whose weight falls outside of the 62-114 kg range. There are no data available from patients with end-stage renal impairment on dialysis, and methylnaltrexone is not recommended in these patients. ***Hepatic impairment:*** Mild to moderate hepatic impairment – no adjustment necessary. Severe hepatic impairment (Child-Pugh Class C) – no data available, and methylnaltrexone is not recommended in these patients. ***Paediatric patients:*** Should not be used in children under 18 until further data is available. ***Elderly patients:*** No dose adjustment recommended. **Administration:** Rotate injection site. Not recommended to inject into areas where skin is tender, bruised, red or hard. Scars or stretch marks should be avoided. **Contraindications:** Hypersensitivity to the active substance or excipients. Known or suspected mechanical gastrointestinal obstruction or acute surgical abdomen. **Warnings and Precautions:** Should not be used for treatment of patients with constipation not related to opioid use. If severe or persistent diarrhoea occurs with treatment, patients should be advised not to continue therapy and consult their doctor. Treatment can result in rapid onset (within 30-60 minutes) of a bowel movement therefore patients should be made aware and be in close proximity to toilet facilities. Methylnaltrexone has not been studied in clinical trials for longer than 4 months, and should therefore only be used for a limited period. Relistor should only be used in patients who are receiving palliative care and added to usual laxative treatment. Not recommended in patients with severe hepatic impairment or with end-stage renal impairment requiring dialysis. Use in patients with colostomy, peritoneal catheter, active diverticular disease or faecal impaction has not been studied. Therefore, should only be administered with caution in these patients. **Pregnancy and Lactation:** Should not be used during pregnancy unless clearly necessary. The decision on whether to continue/discontinue breast-feeding or to continue/discontinue therapy should take in to account the benefit of breast-feeding to the child and the benefit of Relistor therapy to the woman. **Effects on ability to drive and use machines:** Dizziness may occur. **Undesirable Effects:** Very common (≥1/10): abdominal pain, nausea, flatulence and diarrhoea. Common (≥1/100, <1/10): dizziness, injection site reactions (e.g. stinging, burning, pain, redness, oedema). **Legal Category:** POM. **Package Quantities:** Cartons containing: 1 x 0.6 ml vial, or 7 x 0.6 ml vial kit with 7 x 1 ml injection syringes with retractable needle and 14 x alcohol swabs. **Basic NHS Cost:** £21.05 – 1 x 0.6 ml vial, £147.35 – 7 x 0.6 ml vial. **European Marketing Authorisation Number(s):** EU/1/08/463/001; EU/1/08/463/003. For full prescribing information and details of other side effects see Summary of Product Characteristics. **Full prescribing information is available on request from:** : Wyeth Pharmaceuticals, Huntercombe Lane South, Taplow, Maidenhead, Berkshire SL6 0PH. Tel: 0845 367 0098. **Date of Prescribing Information:** 04 July 2008 Code no. ZAPI083 Doc ID 48683

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Wyeth Pharmaceuticals on 0845 367 0098.

References: 1. Relistor 12mg/0.6ml solution for injection. Summary of Product Characteristics, July 2008, Wyeth Europa Limited. **2.** Thomas J et al. New Eng J Med 2008; 358 (22): 2332-2342.

Date of preparation: January 2009
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