Session D: Palliative and Supportive Care

D1 THE ROLE OF THE PSYCHOLOGIST IN A PALLIATIVE CARE UNIT


Today psychologists represent usual and routine clinicians, as anesthetists, oncologists, nurses and social assistants are considered in the U.O.C.P. Team (Organizational Unit of Palliative Treatments). Due to the patients need to cope with suffering and death, two metaphors necessarily linked with Cancer. From a study we conducted on the psychological aspects of terminal phase cancer patients it appears that these have severe difficulties in facing such phase and often answer with mechanisms of depression, anxiety and in some cases with refusal of life. Only seldom the role of psychologists is outlined for the relational role outside the traditional boundaries established with his patient, and therefore in this case his attention is not only for the patient and family but also for the U.O.C.P. Team. This strategic acknowledgment helps direct behaviour of patient and family, sometimes self destructive, which should remain an important psychological point of reference to the patient. Such bilateral strategy of Psychologists, with the team on one side and patient-family environment on the other, needs an optimal team work as the disease often risks to wear out not only the patients but also his family, which would mean to deprive the patient of the fundamental aid of the family itself. We think these types of behaviour correspond also the article 14 of D. L. 502/92 of the Italian National Health System which inspires itself to the quality of medical health assistance and should continuously conform to the needs of its users in order to answer also to expectations that patient and family nourish from the U.O.C.P. Assistance. With this year we have assisted 75 patients. The first approach was carried out by the psychologist with patient and family in separate sessions. The results of these sessions were useful to orientate relations of clinicians and nurses with patient and family. The psychological sessions were weekly fixed, according to the circumstances, and finally two forms were drawn down, medical and psychological, which data could be used to orient the team’s work. Particular importance was given to patient’s and relative’s family’s sense of immanence and resignation as refusal of life. This must represent the first alarm for the whole U.O.C.P. team.

D2 HOME CARE FOR TERMINALLY ILL CANCER PATIENTS: THE MODEL OF UDINE HEALTH DISTRICT (HD)

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Purpose: The aim of this paper is to review the model and 1 year activity data regarding the continuous-home care programme for terminally ill cancer patients (CP) in a HD with a territorial medical oncology service (MOS) integrated in a palliative care network.

Methods: The MOS providing specialist advice (Oncologist-Palliativist, GP) and support for the general practitioner (GP) and nurses managing CP, providing supportive care, pain therapy, infusional therapy, feed tube, clinical follow-up and laboratory examination. 24 hour-continuous-care by nursing and physicians (available during nights and holidays) is required in order to maintain seriously ill (eg with hypercalcaemia, endocranial hypertension, bowel obstruction, etc) and dying patients who want to stay at home. For emergency is available a 24 hours telephone service. The interprofessional team approach including the OP, the GP, oncological nurses (ON), social workers and dietitian, supported by a group of trained volunteers. The team members work with a common agreed goal (patients’Quality of Life, oncological and Therapeutic Impact Questionnaire), having regular meeting during the week and reviews. The home care service is provided upon request from the GP for outpatient or from the hospital doctor (HD) for inpatient; these are visited in hospital by the OP with ON or at home with the GP and together draw up the assistance program.

Results: Data (from Jan 01 to Dec 01) refer to 263 patients; median age 74 yrs range 37-100. Primary tumours sites lung 37 (14%), gastrointestinal tract 50 (19%), gastroenteric track 84 (32%); breast 30 (11%); SNC 10 (4%); blood disease 13 (5%); other 7 (3%). 150 pts (57%) were indicated for discharge by the HD; 113 (43%) were indicated by the GP. Average time of care duration was 75 days: <7days 29 pts, 7-90days 158 pts, >90days 75 pts. Dead in hospital 71 (39%); in nursing homes (RSA) 11 (6%); dead at home 102 (55%). The pts requested 105 oncological visits, 283 medical visits, 1249 nurse interventions; 239 physiotherapeutic interventions. 194 (74%) pts had severe and/or continuous pain at home-care begin, of whom 40 (20.6%) were taking morphin; during the last 2 weeks 104/263 (39.5%) pts were treated with morphin with a medium consumption (MC) of 74.71 mcg. 22(8.36%) with fentanyl 77.2 mcg (MC). 223/0 (6%) peridural catheter. 5/263 (1.9%) had tube feed.

D3 A PROJECT OF PALLIATIVE CARE NETWORK IN THE LOCAL HEALTH UNIT N. 4 “MEDIO FRIULI” (FRIULI VENEZIA GIULIA REGION)

Simona Liguori° Vito Orlando° Mario Casini°

Introduction: After the regional law about palliative care in cancer patients (2000) the Medical Oncology Service (MOS) in Udine Health District (HD) with 50.000 citizens proposed a project of a palliative care network (PCN) connected the MOS with the Departments of Internal Medicine, of Oncology and Haematology of Udine.

Objective: to achieve a program of continuous care in terminal cancer patients, reduction of hospitalization days and access number in emergency division;

Methods: PCN first step is represented by the patient’s signalling by the Departments’ Physician (DP) to the MOS. Afterwards, patients are visited in hospital by the MOS oncologist with the DP for choosing the assistance setting: home care or nursing homes (RSA) and providing the organization of a palliative care program (so-called “protected discharge”). On his return at home the patient will find the palliative team (oncologist, nurses, social workers, trained volunteers) supporting the general practitioner (GP) in pain therapy, artificial nutrition, etc. During the home care, the patient needing a central venous device or a PEG can be admitted in the Department of Internal Medicine subject to agreement of the MOS oncologist with the DP (so-called “protected admission”), bypassing the first ward and avoiding waiting room. In the presence of uncontrolled symptoms or progressing disease the patient will find the palliative team (oncologist, nurses, social workers, trained volunteers) supporting the general practitioner (GP) in pain therapy, artificial nutrition, etc. During the home care, the patient needing a central venous device or a PEG can be admitted in the Department of Internal Medicine subject to agreement of the MOS oncologist with the DP (so-called “protected admission”), bypassing the first ward and avoiding waiting room.

Results: During the first years of activity (Jan 2001-Dec 2001) the protected discharges 162/207 pts (78.6%) of the cases were visited in hospital by the MOS oncologist because of higher intensity of care. 166/207 pts (80%) were admitted in a palliative home care programme with a median duration of care in days 93 (7 days 14pts, 7-90days 88 pts, >90days 61 pts); 41/207 (19.8%) are admitted in RSA from hospital. The protected admission were 7/166 (4.2%) of whom 2 for CVC positioning, 2 for PEG and 3 for Tenckhoff cathether in refractory ascites. The RSA admissions from home were 8/166 (4.8%).

Conclusions: PCN can allow a program of continuous care in patients with advanced cancer, improving their QoL. Besides this, there is a decrease in the days of hospitalization, resulting in cost saving for the Health Service.

D4 PREVALENCE OF COMPLEMENTARY/ALTERNATIVE MEDICINE (CAM) IN CANCER PATIENTS: A SINGLE INSTITUTION STUDY

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Recently CAM has become an important aspect of palliative cancer care. Cancer patients (pts) are turning to CAM for various reasons; most have tried alternative medicine due to the side effects of conventional therapies. Studies to determine the use of CAM by cancer pts reported a wide range of prevalence (7-64%). The lack of a clearly defined CAM and the presence of biases (selection bias, high nonresponse rates, recall bias) in most of surveys published greatly contributed to this variability. Between February and March 2002 we carried out a study to determine the prevalence of use of CAM in cancer pts submitted to chemotherapy in our Oncological Day Hospital. A descriptive self-written questionnaire was administered during the chemotherapy cycles. Pts were asked about their use of current CAM and their reason for using these therapies. The study is ongoing. Today a total of 70 pts entered the study. Characteristics of the pts were: 35 male, 35 women; age group: 3 pts 20-39 years, 25 pts 40-59, 41 pts 60-79, 1 pts >80; tumour site: 22 breast, 19 lung, 15 colorectal, 6 haematological diseases, 8 other tumours. Fifty pts (71%) experienced subjectively significant toxicity by chemotherapy nausea and vomiting 33 pts, mucositis 10 pts, diarrhoea 6 pts, asthenia 5 pts, constipation 19 pts, anorexia 14 pts. Thirteen pts (18.5%) used CAM in order to minimize these side effects. In 62/263 (13%) pts of the cases their use was recommended by relatives and friends, in 38% (5/13) pts by homeopaths and in 15% (2/13) pts by physician. All pts reported to undertake dietary supplements and herbal preparations, with preference for Aloe. CAM were reported helpful in order to reduce nausea and vomiting, asthenia, constipation and to improve appetite in 92% (8/13 pts) of the cases their use was recommended by relatives and friends. In 38% (5/13) pts by homeopaths and in 15% (2/13) pts by physician. All pts reported to undertake dietary supplements and herbal preparations, with preference for Aloe. CAM were reported helpful in order to reduce nausea and vomiting, asthenia, constipation and to improve appetite in 92% (8/13 pts) of the cases their use was recommended by relatives and friends. In 38% (5/13) pts by homeopaths and in 15% (2/13) pts by physician. All pts reported to undertake dietary supplements and herbal preparations, with preference for Aloe. CAM were reported helpful in order to reduce nausea and vomiting, asthenia, constipation and to improve appetite in 92% (8/13 pts) of the cases their use was recommended by relatives and friends.
D5 MEDROXYPROGESTERONE ACETATE AND QUALITY OF LIFE IN THE TREATMENT OF CANCER CACHEXIA

Palliative Care Units of Istituto Oncologico Romagnolo.

Introduction. Although progestins represent the treatment of choice in cancer cachexia clinical knowledge no data exist describing a role of progestins in the quality of life of patients with cancer cachexia. We present preliminary data of a trial in which both quality of life and symptoms are evaluated during a treatment with medroxyprogesterone acetate for cancer cachexia.

Methods. All the patients with a weight loss greater than 10% were considered eligible and enrolled into the trial. The patients with hormone-responsive or haematological neoplasm, or chronic treatment with corticosteroids were excluded from the trial. Appetite (APP), wellbeing (WB), performance status (PS), weight gain (WG), drowsiness (DSS), pain (P), astenia (AST), nausea (N), and overall quality of life (QL) were evaluated at the time of entering the trial, and every 21 days using a Visual Analogic Scale. A biochemical evaluation and TNF-alpha, interleukin 1, interleukin 6 and gamma-interferon dosages were performed before entering the trial and every clinical evaluation. All the patients were treated with medroxyprogesterone 1000mg/die until intractable toxicity or uneffectiveness.

Results. Till today 18 patients have been considered eligible and enrolled into the trial: 7 (38.9%), 6 (33.3%), 4 (22.2%), 3 (16.7%), 4 (22.2%), 3 (16.7%) and 5 (16.7%) patients were considered responders respectively in APP, AST, WB, P, N, PS, DSS evaluation, while no weight gain improvement was observed after a median follow up of two months. 9 patients (50%) were considered responders in the overall quality of life evaluation, with a median time to response of 3 days and a median time to progression of 80 days. No major side effects have been observed till today. No data regarding a possible predicting role of seric citokines, nor any correlation between clinical and biochemical parameters are still available.

Conclusions.our data seem to confirm the role of medroxyprogesterone acetate in the palliative treatment of cancer cachexia, and we hope that either the biochemical evaluation or the citokines dosages could help us to select the subgroups of patients “truly responders” from the “not-responder” ones. Supported by Istituto Oncologico Romagnolo (IOR).

D7 TOTALLY IMPLANTABLE VENOUS ACCESS SYSTEMS (TIVAS): LONG-TERM ANALYSIS OF COMPLICATIONS

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Introduction: during the last decade, TIVAS for prolonged venous access, has been increasingly employed for chemotherapy, parenteral nutrition, i.v. antibiotics and analgesics, blood transfusions, for a safe and adequate venous access. The more and more wide use of TIVAS has made increase the interest for the TIVAS-related complications that need a careful management in problematic subjects as cancer pts.

Purpose: the incidence of TIVAS-related complications in pts with solid tumors afferent to a specialized institution has been evaluated.

Materials & Methods: retrospective study in 543 pts with TIVAS implanted from January 1993 to August 2001 for long-term use, has been performed. 279 female and 264 male, mean age 57,54 (range 20-84), the site of primary neoplasm was gastrointestinal 63%, breast 17%, ovary 5%, lung 4%, head and neck 4% or elsewhere 7%. Indications for the use of TIVAS have been: continuous infusional chemotherapy 65%, lack of peripheric venous access 19%, support therapy 14%, use of vesicant drugs 2%. All the systems has been implanted under local anesthia, 93% in right subclavian vein, with percutanous way. Antibiotic prophylaxis had never been used.

Results: the complications rate of TIVAS has been 14% (38% of them required system removal). To analyze the long term complications rate apart from the catheter insertion technique, surgeon experience or manufacturing defects, we excluded from analysis the pts with immediate post-operative complications; doing so the complications rate became 10%.

Venous thrombosis has been 3%, catheter occlusion reversible 2,2% and irreversible 1,1%, infectious complications 4,6%. These percentages of complications appears low in comparison with literature data.

Conclusions: TIVAS in cancer pts has a high cost-efficiency rate and an evident in 14 subjects (93%). More comfortable feelings were reported by patients and colleagues was observed, associated to the improved subscale scores in the questionnaire: intellectual, relational, managerial, innovative, psychological, imaginative, transpersonal, meditative and bodily methods.

D8 EXPERIENCE OF STAFF SUPPORT GROUP MEETINGS IN MESSINA MEDICAL ONCOLOGY

Marcello Aragona, Leteria Broccio, Pasana De Cataldo, Maria Morelli, Stefania Panetta, Salvatore Pantì, Giuseppe Pastura, Raffaiele Talamo Rossi, Arturo Sicà*, Anna Verna2, Francesco La Torre.
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To look a patient in his eyes during communication and to transmit correct informations, by speaking, touching or silencing (also silence is part of communication), especially when the expectancy or the quality of life are scarce, it is necessary to be, not only to be, but to participate, to feel the other’s fears or anguishs, that anybody carry inside, may drive the physician to remove or eliminate, with them, also the relation with the patient, as triggers for the emotive state and his health formation. A specific self-examination and specific self-examination and support is necessary. For these purpose support group meetings for doctors and nurses were organized following a Course of Communication on health professionals in oncology held in Messina Medical Oncology Unit, in 2001.

The course was didactic-experiential group (9 days and 72 hours), with psychological, imaginative, transpersonal, meditative and bodily methods. Subjects (5 doctors, 5 nurses, 3 biologists, 2 psychologists) were interviewed and assessed with a specific questionnaire, before and at the end of the course. Bimonthly regular support group meetings were oriented to sharing experiences, to improve communications and decrease the sense of isolation in a non-judgemental atmosphere.

Subjective improvement of mood and communications, giving heed to informations, by speaking, touching or silencing (also silence is part of communication), especially when the expectancy or the quality of life are scarce, it is necessary to be, not only to be, but to participate, to feel the other’s fears or anguishs, that anybody carry inside, may drive the physician to remove or eliminate, with them, also the relation with the patient, as triggers for the emotive state and his health formation. A specific self-examination and support is necessary. For these purpose support group meetings for doctors and nurses were organized following a Course of Communication on health professionals in oncology held in Messina Medical Oncology Unit, in 2001.

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Session D: Palliative and Supportive Care

D9 A SIMPLE AND WELL TOLERATED SCALP COOLING SYSTEM IN THE PREVENTION OF CHEMOTHERAPY-INDUCED ALOPECIA

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We prospectively studied the feasibility and activity of a simple ice cap gel method in preventing chemotherapy(CT)-induced alopecia in 98 pts receiving depleting regimens, either in the neoadjuvant and adjuvant or metastatic setting. There were 70 females and 28 males, median age 51 years (range 28-72); the most represented tumor types were breast (53%), lung (18%), and head&neck (10%) cancer. According to the different given regimens the pts were divided into 4 groups: anthracycline-based regimens, (group A: 42 pts); taxane-based regimens, +/- anthracyclines (group B: 26 pts); etoposide-containing regimens (group C: 18 pts); cisplatin-based regimens (group D: 12 pts). All treatments were administered intravenously on outpatient basis. The caps were stored at -25°C, rapidly applied 30 min before the start of the infusion, then changed every 30 min during the drug injection or infusion and over an additional hour after the end of CT. Alopecia was assessed by the method in preventing chemotherapy(CT)-induced alopecia in 98 pts receiving treatment progression while on the second course. Overall, 81% hair protection was achieved in all treatment regimens. Group A: grade 0 alopecia in 89%, grade 1 in 10%; Group B: grade 0 in 85% of pts given taxanes alone, 33% of those receiving taxane+anthracyclines; group C: grade 0 in 30% of pts; group D: grade 2 in 16% of pts, grade 3-4 in 75%. Neither correlation between hair protection degree and presence of liver metastases nor increased incidence of scalp metastases was observed at a median follow-up of 14 months. Compliance was good, with 60% of pts experiencing mild, quickly reversible headaches. Our results are in agreement with the best data published so far, showing an adequate hair loss protection > 80%, with a significant impact in preserving the patient's self-image. Alopecia-preventing systems in specific CT regimens, as anthracycline/taxane combinations, need to be further investigated.

D10 SUPPORTIVE CARE (SC) IN PATIENTS WITH ADVANCED NON-SMALL-CELL LUNG CANCER (NSCLC)


Clinical Trials Office, National Cancer Institute of Naples, Italy.

Introduction and objectives: Literature data on SC assumed by cancer patients are scanty. Aim of this study is to describe SC in patients with advanced NSCLC and to evaluate whether chemotherapy, patients performance status (PS) and age do affect type of SC.

Methods: Data of patients enrolled in 3 randomized trials of first line chemotherapy were analyzed. The ELVIS study (1996-1998) compared vinorelbine (V) vs SC alone in patients ≥70yrs. The MILES study (1998-2000), compared gemcitabine + vinorelbine (GV) with V and G given singly, in pts ≥70yrs. The GEMVIN3 study (1999-2001), compared cisplatin-based (PG or PV) with GV, in patients <70yrs. Drugs given as SC have been classified according to the WHO ATC system. Analysis has been limited to the period of time covering the first 3 cycles of chemotherapy.

Results: SC data were available for 1185 patients (3091 cycles) out of 1312 (90%) enrolled in the three trials. The first five drug categories, ranked by percent of patients assuming at least one drug of the group, are: gastro-intestinal drugs (46%), corticosteroids (35%), analgesics (23%), anti-inflammatory drugs (19%) and drugs for respiratory system (16%). One third of the patients assumed 3 or more different ATC categories. With the exception of growth factors (p=0.01), no significant difference is found in SC comparing pts who received chemotherapy (V) or SC alone in the ELVIS study. Comparing P-based with GV (GEMVIN3 study), more patients in the P-based arm assumed antineutemics (p=0.003) and antiememic drugs (p=0.02), with no difference for other supportive drugs. PS effect was studied in 883 patients who received at least 3 cycles of chemotherapy. P2 patients received antiadjuvants (p=0.04) and corticosteroids (p=0.01) more frequently than PS 0/1 and received, on average, a higher number of drugs (p=0.001). Impact of age on SC was studied by comparing adult (<70yrs) vs elderly (≥70yrs) patients treated with the same chemotherapy (GV in the MILES and the GEMVIN3 studies). Use of antiadjuvants was more frequent in elderly than in the young ones (p=0.001). Cardiovascular drugs are more frequently used in older patients (p<0.001).

Conclusion: In patients with advanced NSCLC, there is a significant presence of poly-pharmacotherapy. Chemotherapy does not markedly affect the use of supportive care, except for some drugs against side-effects. A worse PS produces the use of more drugs, particularly corticosteroids. There is a tendency to prescribe more antineutemics in adult than in elderly patients. Partially supported by APRIC-CTPG.

D11 EMOTIONAL EVALUATION OF CANCER PATIENTS WITH CENTRAL VENOUS CATHETERS (PORT): LONG-TERM ANALYSIS

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Background: use of PORT is now considered a common practice in oncology, for continuous infusion schedules, best supportive care or when peripheral venous integrity is compromised.

Aim: to evaluate emotional implications in a homogeneous oncologic population receiving chemotherapy for advanced disease of gastrointestinal apparatus, carrier of PORT for a minimum time of 12 months (range 12-60).

Methods: in our population, we evaluated the impact on quality of life (QdL), the satisfaction perceived with respect to care received and the incidence of anxiety and/or depression related to presence of PORT for a long time. 32 patients entered the study with characteristics: mean age 59.9 ± 8.12 years; sex 15F 17M. Performance Status (Karnofsky) 60-70: 4 pts; 80-90: 21 pts; 100: 7 pts. Methods of evaluation: Hospital Anxiety and Depression (HAD) scale, EORTC QLQ C30 questionnaire, visual analogical of care satisfaction (VAS), semi-structured interview.

Results: 3/32 pts refused the trial (drop-out). Values of HAD. EORTC and VAS scales are:

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<th>MED</th>
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<tr>
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<tr>
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<td>1</td>
<td>13</td>
<td>5</td>
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<td>EORTC (28)</td>
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<td>29</td>
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<td>4.9</td>
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<td>5.2</td>
<td>10</td>
<td>8.96</td>
<td>1.06</td>
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Conclusions: in our population, levels of anxiety and depression are in line with literature data. However, a group of pts are sub-threshold for major depressive disease (especially depression), therefore in a higher risk for development of clinical depression/anxiety. The interview shows that presence of PORT for a long time is related with a major ‘medical presence’ in the life of pts, with a relevant risk of dependency anguish (from both doctor and disease) but not necessarily related with lifestyle limitations, as sleeping and self-care. PORT is a useful tool for oncologic pt and sanitary operator, in terms of safety and comfort; but every patient must carefully examinated (biochemical, emotional and psychological), for a real ‘global approach’ to the neoplastic patient.

D12 A MODEL OF ONCOLOGY HOME-CARE (OH) UNIT IN THE PROVINCE OF SIENA: RESULTS OF ONE YEAR OF ACTIVITY

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In 2000, in the province of Siena (Tuscany, Italy) a Unit of Oncology Assistance was activated, made up of two Day Hospital Units and of an assistential home-care network divided into three districts (area Senese, Val d’Elsa, Val di Chiana). The aim of the OHC is to allow a continuing medical assistance of terminal ill cancer patients from hospitals to their own home. To activate the OHC, cancer patients had to require palliative care in order to improve their quality of life, otherwise unsuitable to be performed in Hospitals. Moreover, other inclusion criteria were an adequate family support, and an informed consent taken from the patient, the family and the general practitioner. The team of OHC consisted of two medical oncologists, a radiotherapist, and 15 nurses from the Azienda USL 7, except for the area Senese where the assistance was carried out by the QUAVIO (Qualità di Vita in Oncologia) Association, with 30 voluntary nurses, a psychologist and 8 volunteers. In 2001, we assisted 397 patients (M/F 229/168), of whom 342 (M/F 202/140) were the new cases. At the time of the first visit, ECOG performance status was 3 to 4 in 155 patients (39%). Two-hundred seventeen patients (55%) died, of whom 130 (60%) at home. The median length of assistance was 70 days. The diagnostic approach and the therapeutic management of patients was possible in 90% of cases, by weekly meeting at the Day Hospitals. Remarkably, 60% of patients died at home, thus reaching one of the main aim of our activity. In conclusion, this model of OHC may allow the integration of a qualified and specialist team, and an optimal planning of therapy.
D13 ANEMIA MANAGEMENT IN CANCER PATIENTS RECEIVING CHEMOTHERAPY (CT): INTERIM ANALYSIS OF SURVIVAL


Aim of the study: produce an interim analysis of survival of anemic cancer pts during 1 year follow up after starting antiemic treatment.

Patients and methods: of 72 pts entered an ongoing open-label study optimizing EPO cost, from June 2000 to March 2001, 37 pts were evaluable for survival. Pts age ranged from 31 to 80 years, 21 males, 16 females, 35 (95%) solid tumors and 2 (5%) multiple myeloma, 18 (49%) advanced diseases, were divided into two arms: Arm A (Functional Iron Deficiency (FID): they had % transfusing saturation (%TS) < 20% and/or % of isocromic red cells (%IC) >10%, these pts were treated with iron (Fe) gluconate iv 250 mg/week until %TS coming up 20%. Arm (B) Anemia gr. 1 (WHO/NCTI) all the pts with Hb <10.5 g/dl were immediately treated with Epo beta 10.000 U three times weekly for 2 weeks then reevaluated. Fe supplementation iv (same upfront dose) only if %TS was <20% or %IC >10%. Responders started maintenance Epo 10.000 U/w all along the CT curve. All pts groups were treated for a median of 2 months.

Results: Arm A: 18 pts exclusively treated with Fe gluconate iv (15 % pts advancing setting and 3 pts advanced): at march 2002, 15 pts (83%) are alive. The pts (11), all advanced, with a median survival of 13 months (range 11-15). Arm (B): 19 pts with EPO +/- Fe iv, 9 pts (47%) are alive. Ten pts (53%), all metastatic, dead with a median survival of 6.5 months (range 2-17).

Conclusion: our preliminary findings don’t support the hypothesis of survival advantage by EPO +/- iron treatment in metastatic cancer pts and doesn’t generally restate previous reports. However systematic treatment of anemic cancer pts under CT is mandatory in the adjuvant setting. The pts age ranged from 31 to 80 years, 21 males, 16 females, 35 (93%) solid tumors and 2 (5%) multiple myeloma, 18 (49%) advanced diseases, were divided into two arms: Arm A (Functional Iron Deficiency (FID): they had % transfusing saturation (%TS) < 20% and/or % of isocromic red cells (%IC) >10%, these pts were treated with iron (Fe) gluconate iv 250 mg/week until %TS coming up 20%. Arm (B) Anemia gr. 1 (WHO/NCTI) all the pts with Hb <10.5 g/dl were immediately treated with Epo beta 10.000 U three times weekly for 2 weeks then reevaluated. Fe supplementation iv (same upfront dose) only if %TS was <20% or %IC >10%. Responders started maintenance Epo 10.000 U/w all along the CT curve. All pts groups were treated for a median of 2 months.

Results: Arm A: 18 pts exclusively treated with Fe gluconate iv (15 % pts advancing setting and 3 pts advanced): at march 2002, 15 pts (83%) are alive. The pts (11), all advanced, with a median survival of 13 months (range 11-15). Arm (B): 19 pts with EPO +/- Fe iv, 9 pts (47%) are alive. Ten pts (53%), all metastatic, dead with a median survival of 6.5 months (range 2-17).

Conclusion: our preliminary findings don’t support the hypothesis of survival advantage by EPO +/- iron treatment in metastatic cancer pts and doesn’t generally restate previous reports. However systematic treatment of anemic cancer pts under CT is mandatory in the adjuvant setting. The possible influence of EPO treatment on tumor hypoxia and consequently better tumor control and survival is an important question for the future.

D15 PHASE II STUDY OF SUBCUTANEOUSLY ADMINISTERED INTERLEUKIN-2 IN COMBINATION WITH MEDROXYPROGESTERONE ACETATE (MPA) OR ANTIDIABETIC MEDICATION AS AN ADJUVANT OR MARGINAL THERAPY IN ADVANCED CANCER PATIENTS RESPONDERS TO PREVIOUS CHEMOTHERAPY

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An open, non-randomized phase II study was carried out including patients with advanced solid tumors who exhibited clinical response or disease stabilization to chemotherapy, to receive a maintenance treatment with recombinant Interleukin-2 (rIL-2) plus medroxyprogesterone acetate (MPA) plus antioxidant agents Alpha-Lipoic Acid (ALA) and N-Acetyl Cysteine (NAC). The first study endpoints were to optimize EPO treatment on tumor hypoxia and consequently better tumor control and survival is an important question for the future.

To evaluate incidence of sleep disorders and their correlation with both QoL and awareness of disease a 26-items questionnaire and three visual analogue scale (VAS) were administered. Patients were asked to fill out the questionnaire (each items ranking in three points: never, sometimes and always). Moreover they were requested to mark a point on each of three 100 mm long horizontal lines on which extremes were labelled with zero (‘worst QoL’, ‘quite severe disease’, and ‘very difficult to cure’) and 100 (‘best QoL’, ‘not severe disease’ and ‘very easy to cure’).

Anwers were classified in ‘good QoL’, ‘not severe disease’ and ‘easy to cure’, if a point in the 70-100 mm interval was chosen, and ‘bad QoL’, ‘severe disease’ and ‘difficult to cure’ if a point in the 0-30 mm interval was chosen. Fisher's exact test was used to evaluate the significance of the relationship between responses to each item of the questionnaire and each VAS. One hundred ten patients (median age 55; range 30-78) affected by breast cancer were evaluated. Seventy-two patients were in follow up at least from one year and 38 were treating with adjuvant chemotherapy. Three patients did not suffer for any sleep disorders. 16 felt their disease as ‘severe’ and 9 ‘difficult to cure’, 11 defined as ‘bad’ their QoL. The percentage of patients who needed more than 30 minutes to sleep was lesser among those who thought their disease ‘easy to cure’ (17%) than among the others (37% and 38% respectively) (p<0.05). The percentage of patients who sometimes needed to sleep in the day-time among those who thought their disease ‘easy to cure’ (33%) or ‘not severe’ (29%) than among the others (54% and 56% respectively) (p<0.04). Patients who had never,sometimes, always difficult to sleep exhibited a good quality of life in 57%, 38% and 25% respectively (p<0.02). Patients who remained awake in the high-time observed. 30 minutes never/sometimes/always exhibited a good QoL in 57%, 35% and 25% (p < 0.07). Patients who were awake earlier than usual never/sometimes/always exhibited a good quality of life in 53%, 38% and 27% respectively(p(0.09). Patients who took hypnotics drugs never, sometimes, always difficult to sleep exhibited a good quality of life in 44%, 23% and 15% respectively (p < 0.04). Sleep disturbances were less frequent in patients who felt their disease ‘easy to cure’ and/or ‘not severe’ and had a negative impact on QoL.
D17 CENTRAL VENOUS CATHETER (C.V.C.) RELATED COMPLICATIONS IN PATIENTS (PTS) WITH ADVANCED CANCER FOLLOWED AT HOME: OUR EXPERIENCE


Introduction
C.V.C. related complications are prevalently constituted by infections, thrombosis and removals. The most frequent is certainly the infection, that in U.S.A. is calculated in about 300.000 cases/year, with an incidence that varies between 2.7% and 60%. These percentages, so different, are due to different risk factors, according to the type of catheter, the site of insertion, the duration of catheter placement and, last but not least, the site of care (home vs hospital). The same changeability is observed in thrombosis incidence during the course of different kinds of tumors (for instance, 25.6% in lung cancer, 15.2% in intestinal tumours, 2% in breast cancer).

Patients and methods
In our study we estimated the incidence of C.V.C. related complications in pts with advanced cancer followed by our home care unit. Since 01/11/2000 to 31/10/2001 we followed at home 617 pts and 117 (19%) of them had a C.V.C.

Conclusions
Our data, comparable with those of literature, confirm that it’s possible to use C.V.C at home, with the support of skilled nurses and, often, of “skilled” relatives.

D19 PALLIATIVE CARE IN PLEURAL MESOTHELIOMA

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Casale M. is a town affected by pleural mesotheliomas high incidence, connected with an environmental and professional exposure to asbestos(20-25 cases per years).At this days, we don’t know a successful therapy; therefore to ensure a better quality of life, we should seek focusing on 3 goals: maximum strength in pain and dyspnoea relieve; maximum easiness of relatives. We evaluated the response accordingly with a scale from 1 to 5(1 is normal, 5 is worst) measuring the dosage of morphine and benzodiazepines. We treated 12 patients (8 males, 4 females, 57-82 age, P.D. 8-60 yrs) with advanced cancer and in 1 patient with myeloma. All the complications were diagnosed only with a clinical approach: neither blood culture nor instrumental researches were carried out to a diagnostic confirmation, both the peculiar characteristics of pts (they couldn’t be moved by their bed at home) and the difficulty to execute correct blood culture at home.

Conclusions
The exam of this experience’s first results strongly suggests that our therapy successfully controls pain and dyspnoea. The responses evaluated with SDS were positive in 75% of patients who declare their symptoms passed from 4-5 to 1-2 degrees. Nevertheless the treatment’s schema should be as a guideline; the medication must be customized to meet the individual needs, motivations and desires. The respect of patient will must always be our priority.

D20 PAIN PREVALENCE IN AN ONCOLOGICAL HOSPITAL

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Cancer pain is still a relevant issue, especially in oncological settings. We investigated the pain prevalence at the IEO, a 200-bed oncological hospital, compared with the main specialized centers (with the exclusion of neurosurgery, pediatrics, and orthopedics). It has been established in 1994, and pain control has always been included in internal activities. On 2 different days, during both spring 2000 and 2001, all inpatients, received a 11 item VAS self-administered questionnaire, including pain. This item was anchored to the extremes by the expressions “no pain” and “the worst pain possible”, with a 0-100 range of values. Pearson χ² Test, showed no statistical difference between the 2 years (p=0.35). For this reason data are presented as a cumulative collection. A total of 590 patients, female=62%, age: <45 yrs = 24%, 45-60 yrs = 38%, > 60 yrs = 38%, median PS (ECOG)=1, were surveyed. Pearson χ² Test, for comparison of the four pain intensity classes between medical (N pts=250) and surgical departments (N pts=340) approached statistical significance (p=0.0567), point out a possible higher degree of suffering among surgical patients. Pain Free Hospital initiatives, such as those supported by WHO for chronic cancer pain deserve more attention.
**D21 NATIONAL HEALTH SERVICE (NHS) NO-PROFIT INTEGRATION FOR PATIENTS WITH ADVANCED CANCER: THE FONDAZIONE F.A.R.O. O.N.L.U.S. EXPERIENCE**

Alessandro Valle, Maria Rita Zappoli, Gloria Gairollo, Oscar Bertetto.

**Introduction**

The Fondazione F.A.R.O. O.N.L.U.S. was born with the purpose of caring at home patients with advanced cancer. After few years, the need of a better integration with NHS was felt, to guarantee the best and complete quality of care to patients and their families. This integration permitted to complete the assistance program with the Hospice Oncologico F.A.R.O., that takes in patients who cannot be followed at home.

**Organization**

The Fondazione F.A.R.O. O.N.L.U.S. takes care of patients with advanced cancer, according to palliative care principles, through two staffs constituted by doctors, nurses, psychologists, physiotherapists, volunteers, all skilled in palliative care; many specialists (oncologists, dermatologist, neurologist, urologist, etc.) are available, if necessary. The assistance is guaranteed all days of the year since 8 a.m. to 8 p.m.

Conventions with NHS have been activated: this is very useful for patients and their families, both for better collaborative intercourses with general practitioners and also for practical reasons, like the free availability of therapeutic supports and auxiliary nurses.

Since 1989 to March 2002 Fondazione F.A.R.O. O.N.L.U.S. has followed at home 4319 patients, 663 in 2001, 49,9% of them in convention with NHS.

In September 2001 Hospice Oncologico F.A.R.O. began to take in patients with advanced cancer who cannot be assisted at home for family or environmental problems. The hospice, in which the staff applies the same palliative care principles of home care, has 14 single rooms, with bath inside and chair-bed for relatives; it was born by conventions with NHS, Compagnia di S. Paolo, Azienda Ospedaliera S. Giovanni Battista (Torino), Ospedale S. Giovanni A.S. (Torino), Ospedale Mauriziano (Torino), IRCC (Candiolo).

**Conclusions**

In our experience a tight integration NHS/no-profit could improve the care to patients with advanced cancer, both at home and in hospice, and we think that this integration should be encouraged further on.

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**D22 LOW DOSE WARFARIN PROPHYLAXIS OF VTE IN DIFFERENT CATEGORIES OF ADVANCED CANCER PATIENTS**

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**Introduction**

Cancer itself is known to be one of the most potent risk factors of venous thromboembolism (VTE). Moreover advanced stages of disease, chemotherapy and the presence of central venous lines are additional oncologic factors increasing the risk of VTE. Levine et al (Lancet 1994) demonstrated that low-dose warfarin is an effective prophylactic regimen allowing a reduction of symptomatic VTE in women affected by advanced breast cancer during chemotherapy. Aim of the present observation was to evaluate whether the same warfarin schedule proposed by Levine - that is 1mg warfarin daily for the first 6 weeks than increasing INR between 1.3 and 1.9 - is feasible and safe also in patients suffering from advanced malignancies other than breast cancer treated with chemotherapy and carrying central venous lines.

**Material and methods**

70 patients, mean age 61.5 (median 63 yrs), were evaluated, all affected by advanced (M+ or M-) disease. 68% of them suffered from colorectal cancer, 12% from breast cancer, 7% from pancreatic cancer and 4% from stomach cancer. All patients were receiving chemotherapy and were carriers of central venous lines. The mean duration of oral anticoagulant treatment (according to Levine schedule) was 8.5 months (median 7 months).

**Results**

- Occurrence of symptomatic (objectively confirmed) VTE events two pulmonary embolism and four deep venous thrombosis was observed in 5 patients (7.1%): this accord with 1 event/97 months of anticoagulant treatment.

**Conclusions**

These preliminary results seem to indicate that warfarin prophylaxis according to Levine is feasible and safe also in cancer patients with advanced disease other than breast cancer. This schedule has been adopted at our Oncology Service for prophylaxis of VTE in all patients carrying central venous lines during the treatment with chemotherapy for advanced disease.

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**D23 ONE YEAR OF COLLABORATION BETWEEN INTEGRATED HOME CARE (A.D.I.) AND FONDAZIONE F.A.R.O. O.N.L.U.S. (F.A.R.O.), APPLIED TO PATIENTS (PT) WITH ADVANCED CANCER, IN A MAINLY MOUNTAINOUS AREA**

Simone Veronese*, Claudia Cugno*, Maria Rollero*, Alessandro Valle**, Oscar Bertetto**

**Introduction**

Home care for pts with advanced cancer presents different problems in terms of service organization depending on the specific geographic features of the area.

**Patients and Methods**

In 2001 A.D.I./F.A.R.O. service followed at home 32 pts in A.S.L.5/SDS (Susa valley). All pts were affected by advanced cancer (presumed prognosis ≤ 4 months, Karnofsky performance status ≤ 40) and followed according to palliative care principles. The first visit was always conducted within the fourth working day from the moment the case was signalled.

All pts were provided with free drugs and facilities already included in A.D.I. scheme and these were given straight away (drugs on the same prescription day). Total assistance days were 529 (average of 16.5 days per patient (pt)). Among the 32 pts followed, 30 (93,7%) died: 24 (80%) of these at home, 4 (13,3%) in hospital, 2 (6,7%) in hospice: 2 pts (6,3%) were still alive at the end of our study and still assisted at home.

550 visits were performed at home: 209 (38%) medical visits (MV) and 341 (62%) were home visits (HV). Of the 209 MV (average of 6.5 visits per pt), 189 (90.5%) were scheduled in working days, 5 (2.4%) at weekends. 9 (4.3%) were MV due to emergency in working days, while 6 (2.8%) at weekends.

Of the 341 HV (average of 10.7 visits per pt), 261 (76.5%) were scheduled in working days, 70 (20.6%) at weekends. 6 (1.8%) were HV due to emergency in working days and 4 (1.1%) at weekends.

**Conclusions**

In our experience, an appropriate integration between National Health Service and no-profit allows an efficient home care of advanced cancer pts, even if living in mountainous areas, when its possible to provide quick care and immediate supply of drugs and necessary facilities.
Session D: Palliative and Supportive Care

D25 THE FEMALE CAREGIVER CONTRIBUTES TO REDUCE THE STATE OF ANXIETY AND DEPRESSION OF CANCER PATIENT IN CHEMOTHERAPY TREATMENT


Depression and anxiety in the patient are often associated to the appearance of the same symptoms in the caregivers. In the meantime the caregiver can influence the patient expression of these symptoms. The purpose of the study was to verify the influence of the caregiver sex on the emotional state of the patient.

20 patients and their caregivers where considered. During this experience the caregivers interviewed were all sons and daughters of the patients. All the patients were treated with chemotherapy. The patients median age was 66 years old (range 52 to 77); the caregivers median age was 36 (range 26 to 49). Female sex represented the 70% of the patients and 60% of the caregivers. The instruments used were STAI Y 1 and 2, IPAT CDQ and some MAC items. A significant difference was found between the depressive state and the sex of caregivers (F=4.68, p<0.0407); the female part of the caregivers, though having an increased average level of depression (median = 59.84) rather than the male one (median = 55.92), has less influence depressive state of the patient (median = 58.74) rather than male caregiver (median = 69.08). The patients anxiety also shows a relevant difference with the sex of their caregiver (F = 6.86, p < 0.0137); anxiety is more accentuated in the female caregiver (median = 53.69) than in the male one (median = 49.38), but it is stronger in the patients helped by male caregivers (median = 49) rather than the female one (median = 43.89).

The female caregiver contributes to reduction of the state of anxiety and depression in patients treated with chemotherapy.

D26 ROLE OF A DIETETIC PROGRAM ON WEIGHT GAIN AND METABOLIC SIDE-EFFECTS IN BREAST CANCER PTS

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INTRODUCTION Weight gain is a common side effect among breast cancer patients receiving chemotherapy (CT).

PATIENTS AND METHODS We describe our experience on 78 breast cancer patients , aged between 33 and 77 years, with weight gain and mean BMI 31.3. Twenty-eight of them already had one or more metabolic side effects (diabetes, hypertension, dislipidemia). Fifty per cent of the patients had no physical activity and only 21% had a regular physical activity. RESULTS Sixty per cent of patients who followed our dietetic program had a median weight decrease of 3.1 Kg. 17% had no weight change and 23% had a median weight gain of 2.1 Kg. We observed a drop-out of 28%.

CONCLUSIONS Weight gain in women receiving adjuvant CT is a well known side effect that appears as a multifactorial side effect related to the length of treatment, type of CT, menopausal status.Life style is also greatly involved in the pathogenesis (changes in dietary intake and in levels of physical activity). In our experience an early personal dietetic program has a great impact on the prevention and control of weight gain and metabolic aspects related to CT, in order to prevent or reduce the weight gain and to induce a better control of metabolic complications.

D27 QUALITY ASSISTANCE INDICATORS IN ADVANCED CANCER PATIENTS


Cancer diagnosis is a traumatic event, sometimes catastrophic. The prevalent feeling in these patients is the angry refusal of an incurable disease and the death. The assistance given to incurable sick must take into consideration these aspects and it must be based on the comprehension and participation in patient's and family's sorrow. To establish a true relationship with the patient, doctors should give up the language of the science in order to fulfil the distance between them and the sick. People working with cancer patients sometimes prefer to use a "official" language, but behind this behaviour we can spot a defensive attitude which purpose is to ensure the health worker from the anxiety and deep emotions that this type of communications implied. A helpful relationship is based on an authentic support in which the health workers must be able to listen to the person and to be involved as a man before than professional. Starting from these considerations we have conduct a research which goal was to evaluate the quality of the assistance delivered to cancer patients. The research is based on evidence of 72 people who lost a relative, and who have used the Domicile Assistance Service. The protagonists involved in an action-research, are members of a care team and care givers who have looked after a relative during year 2000. Aim of our research is to assess the quality measures of patients and families cared by “F.A.R.O home care” team, using an interview presented to the families by a psychologist.

In this way the research assesses the needs of the patients and families and suggests how to improve assistance.

Data obtained underlined that a good alliance between family and team, a good awareness of the diagnosis and prognosis from the patient and an open and harmonious communication between team/patient/relatives allowed a good assessment and help the family to work out the relative's death.

D28 PSYCHOLOGICAL DISTRESS: A STUDY IN NEWLY DIAGNOSED CANCER PATIENTS AND IN PATIENTS UNDERGOING TREATMENT

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The aim of this prospective study was to identify psychological distress and associated specific needs in newly diagnosed oncological pts and in pts previously treated or undergoing treatment with different modalities. From October 2001 to February 2002, 140 inpatients at the Divisions of Medical Oncology A, B and C, of Radiation Oncology and Oncologic Surgery at our Institution were interviewed by means of self-administered questionnaires for the evaluation of needs (NEQ) and of anxiety and depression (HADS). Both newly diagnosed pts (new pts) and pts undergoing treatment for a maximum of 6 months (old pts) were evaluated. 72 pts were male, 68 were female. 88 pts were new, 52 were old. Median age was 54 years. 79% of pts has attended school for 8 years or more. 49% of pts wished to have more information on diagnosis (old 24%, new 26%, p<0.01), 70% on prognosis (old 34%, new 66%, p<0.01), 43% would like to be more reassured by physicians (old 27%, new 73%, p<0.02), 25% wishes to talk to a psychologist (old 18%, new 82%, p<0.01). 53% of pts present psychological distress (HADS > 14, old 26%, new 74%, p<0.01). Of these latter pts, 58% is <55 years old, 53% is male, 84% attended school for ≥ 8 years. As compared with the group of pts without psychological distress, 58% of pts with HADS >14 wishes information on prognosis (p<0.03), 67% needs more reassurance by physicians (p<0.01), 79% reveals the need to talk to a psychologist (p<0.01), but only 39% of them actually expresses this need. As far as the need for reassurance by physicians and the need to talk to a psychologist are concerned, the differences between pts with HADS >14 and >14 remain significant in the group of new pts only (p<0.02 and p<0.01 respectively). In conclusion, in the absence of information on the situation before the onset the disease, it is difficult to evaluate whether a relative paucity of information causes psychological distress or the latter is associated to a greater need for information. These findings are more frequent among new pts, suggesting the need for a more active engagement of physicians in providing information to pts during the diagnostic phase.
D29 SEDATION FOR PATIENTS (PTS) WITH ADVANCED CANCER FOLLOWED BY A PALLIATIVE CARE UNIT: A STUDY IN TURIN

Ferdinando Cancell1, Marilene Filbet2, Alessandro Valle3, Oscar Bertetto1

Introduction

Sedation is a medical procedure used to palliate symptoms, refractory to standard treatment, by intentionally clouding patient’s consciousness. A recent review (september 2001) of literature of the last ten years shows that percentage of terminal pts followed at home, in hospital or in hospice, who needed pharmacological sedation in order to relieve refractory physical or psychic symptoms, varies between 1% and 72%, up to the average of 25%. In this study we evaluate such data by the light of the experience of Fondazione F.A.R.O. O.N.L.U.S., which follows pts at home and in hospice.

Patients and methods

During 2001 the Fondazione F.A.R.O. O.N.L.U.S. followed 726 pts with advanced cancer, according to palliative care principles. Intentionally sedated pts with drugs were 41 (5.6%). Among these, 51.2% reached a deep level of sedation (no answer to any kind of painful stings). The most frequent causes of sedation were agitation (37.5%), pain (20.3%), dyspnoea (18.8%) and emesis (12.5%). 77% and 62.5% of sedated pts, respectively for pain and for emesis, had the symptom evaluated 2 or 3 in the “TIQ” scale already during the first visit. 3 pts (7.3%), two of whom in hospice, were sedated for refractory existential distress and in one of these cases was recorded a suicidal attempt. In 9 pts (22%) depression in remote pathological anamnesis, therefore not reactive to standard treatment, by intentionally clouding patient’s consciousness. A control group does not allow to dimostrate the efficacy of our model of assistance in order to: 1. suggest guidelines about CVD use for POLO NORD Group. 2. perspectively check complications and thromboembolic events.

POLO NORD Group: Oncology Units of Vimercate, Como-S.Anna, Sondrio, Gorgonzola, Como-Valduce, Lecco-Osp., Lecco-Mangioni, Monza, Milano- Fatebenefratelli, Erba, Milano-H.Sacco, Gravedona

D30 CENTRAL VENOUS DEVICES (CVD) IN NEOPLASTIC PATIENTS: THE POLO NORD GROUP EXPERIENCE

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Introduction

The use of CVD has become common practice in oncology, both for the delivery of drugs by continuous infusion and for solving troubles related to difficult venous accesses. The aim of this retrospective observational study is to analyse the experience related to application and use of CVD in the 12 POLO NORD Group Oncology Services.

Methods

From May 1995 to February 2002, 843 CVD have been placed in 791 patients. 709 were port-a-cath and 134 percutaneous permanent catheters. All CVD have been placed under local anaesthesia and a chest Xray was right away performed after the procedure. Median age of the patients was 59 years (16-81), and mean time of CVD permanence was 10 months (1-65). 356 (45%) patients suffered from colorectal cancer, 198 (25%) from breast cancer, 67 (8.5%) from gastric cancer, 24 from lung cancer, 22 from pancreatic-biliary tree cancer, 124 other neoplasms. 151(19%) pts assumed antithrombotic prophylaxis with low dose Warfarin in the 6 months before CVD application. 791 patients; 709 were port-a-cath and 134 percutaneous permanent catheters.

Results:

we observed 70/843 (8.3%) complications CVD related (5 PNX, 9 misplacements, 16 infections, 6 catheter ruptures, 6 disconnections, 19 occlusions, 3 decubit and 6 bleedings); moreover, we noticed 48/791 (6.0%) thromboembolic events (5 pulmonary embolisms, 27 deep venous thrombosis and 16 superficial thrombolobitits), according with 1 event/175 months of CVD permanence. 32 (3.8%) CVD were removed due these complications, while 21 CVD were removed according patients will or end of therapy.

Conclusions:

we consider CVD use as high practice utility for patients quality of life. Regarding to their wide use and frequent troubles CVD related, there is urgent need to organize an “ad hoc” regional registry to collect a multicentre experience in order to:

1. suggest guidelines about CVD use for POLO NORD Group.
2. perspectively check complications and thromboembolic events.

* POLO NORD Group: Oncology Units of Vimercate, Como-S.Anna, Sondrio, Gorgonzola, Como-Valduce, Lecco-Osp., Lecco-Mangioni, Monza, Milano- Fatebenefratelli, Erba, Milano-H.Sacco, Gravedona

D31 PALLIATIVE CARE IN NEURO-ONCOLOGY: CONTINUATIVE HOME CARE FOR BRAIN TUMOR PATIENTS

Ranieri Cit, Patrizia Salis, Paolo Tisei, Michela Caroli, Pino Guastamacchia, Orazio Lembo, Gabriella Maggi, SilvanoVita, Alessia Zizzari, Alfredo Pompei and Andrea Pace

Neuro-oncology home care staff, Regina Elena National Cancer Institute

In the Regina Elena National Cancer Institute of Rome we began since October 2000 a comprehensive home rehabilitation and palliative care program for the patients discharged from our Neurosurgical Division. The aim of this model of assistance is to meet patient’s need of care in the last stage of disease, to provide home palliative care, to facilitate death at home and to reduce rehospitalization. Until December 2001, 138 patients were followed. More frequent symptoms in the terminal phase were dysfagia, lethargy, epilepsy and headache. Non-neuropathologic complications included deep venous thrombosis (8.7%), pulmonary infection (10.8%), adverse effects to medication (chemotherapy, antiepileptic drugs, steroids). Rehospitalization occurred in 32% of patients due to epilepsy, pulmonary infection, neurologic deterioration. 67% of patients were able to remain at home to die. The lack of a control group does not allow to demonstrate the efficacy of our model of assistance, however the results of our study concerning death at home, number of rehospitalization, quality of life and satisfaction with the care received, seem to indicate that a continuative home care program may have a positive impact on needs of care of brain tumor patients.

D32 A MODEL OF U.O.C.P IN CASALE MONF

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The U.O.C.P of Casale Monf. was decided in December 1998.It operates in cooperation with the Association of Volunteers VITAS, with which ASL 21 has entered into an agreement.VITAS consists of volunteers, professional nurses and other people. The professional nurses of VITAS are all hospital workers who do the activities of assistance at home, outside their working hours.

COMPOSITION OF UOCP

• 1 surgeon
• 4 doctors: 2 oncologists, 1 algologist (If necessary,availability of 1 gastroenterologist and 1 surgeon)
• 5 professional VITAS nurses(all hospital workers)
• 1 VITAS psychologist
• 2 VITAS physiotherapists
• 26 VITAS volunteers

All operators have followed trainings in palliative care before becoming part of UOCP.

FUNCTIONS OF UOCP

• taking charge of oncological terminal patients at home
• consultancy at home
• consultancy in the Hospital
• permanent training of the workers
• spreading of the culture of palliative care

All these functions are carried out in close cooperation and interchange with the ADI professional nurses.

ACTIVITIES UOCP (Sept.2000-Dec.2001)

• N of patients taken care at home: 135
• N of patients who died at home:95
• N of patients who died in Hospital:29
• N of patients alive:11
• N of patients deaths:11
• N of patients living at home/patient:1.6 months
• N of patients needing a home care diagnosis:6.7
• N of home visits:183
• N of team meetings:48 (about1/week)
• N of oncological visits:161/month

Assessment questionnaires have been handed out to the patients and to the relatives after the death of the patient,with regard to the appreciation of the assistance(98% of compliance)

FUTURE GOALS

• increase of UOCP staff
• organisation on a stand-by system in week-end
• covering the period of 24 hours assistance
D33 WRITING CLINICAL REPORTS
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Fondazione F.A.R.O. O.N.L.U.S. – Torino - Italy
A palliative care team investigates the use of clinical reports at the patients’ home.
Considering the number of home visits made by medical professionals, clinical reports are crucial instruments for providing adequate assistance.
If the reports are readily available to the patient and their family, they should be prepared to provide a comprehensive and complete description of the clinical status, medical provisions and assistance provided. Misleading or unclear reports could create anxiety and incomprehension to the family members and be confusing to new or different assisting professionals.
The study presented on use of clinical reports by the team members is divided into a four-step programme.
1. Elaboration and presentation of a questionnaire to explore five areas (what to write, to whom, how to write, why to write, when to write).
2. Data elaboration and singling out critical areas.
3. Discussion groups and team meetings with the aim to uniform and develop the use of clinical report.
4. To conclude this first phase, guidelines have been prepared for compiling the clinical reports, comparing the potential or innovative critical points with a legal consultant.

Conclusions
Clinical reports are indication of the organisational capacities of the service. It permits gathering of information regarding the objectives and procedures of the case in question and their integration. This work is therefore part of the permanent training process of the team involved in home care: nurses, doctors, physiotherapist and psychologists. We retain also that the application of guidelines can be a stimulating and useful experiment in a field in which there aren’t precise regulations yet.

D34 TRANSDERMAL FENTANYL AND PAIN CONTROL IN NEOPLASTIC PATIENTS: OUR EXPERIENCE
Anna Bene, Marcello Aragona*, Carmelo A. Buda**, N. Caristis**, R.M. Merendino**, S. Gangemi**, P. Rizzotti, O. Ferrati, G. Altavilla**, F. La Terra**, Department of Internal Medicine, ^ Medical Oncology Unit, *Department of Human Pathology, Policlinic “G. Martino” University of Messina, Medical School, 98125, Messina - Italy
The overall purpose of this study is to evaluate the impact of Fentanyl on quality of life of patients affected by cancer. From January to August 2001 we selected 29 patients (23 males, 6 females; median age 65.2 years) affected by solid metastatic cancer who were yet under treatment with chemo- and/or radio-therapy (ECOG Performance Status, degree 1, Karnofsky 70-80). A Fentanyl, 50 mg transdermal patch has been administered every 72 hours and the sites and features of pain, somatic, visceral, neuropathic, nervous have been registered. A personal evaluation of pain has been requested to the patients asking them to use the Visual Analog Scale (VAS), with 0 to 10 score in which “0” is absence of pain. Furthermore, the patients have been asked to answer to a question of life-index (QL-Index) Spitzer’s questionnaire, referring to the ultimate week and regarding activity, daily life, health, psychological support, general mood, in which a low score witnessed to a good quality of life.
Among the 29 patients, 5 are already dead, the other 21 continued the antalgic treatment, with transdermal Fentanyl at every 72 hours, with good control of pain. In fact, at the VAS evaluation, a decreasing of the mean from 8.3±1.3 to 7.4±0.7 (p<0.01) has been observed, meaning a better management of pain itself. QL-Index analysis reported a quality of life’s improvement: increase of the scores from an average of 4.5±1.7 before Fentanyl administration to 6.2±1.6 (p<0.001) after one week of treatment. Side effects such as constipation has been reported by almost all the patients, while two of them referred nausea and vomiting resolved with antiemetic drugs.
Although this study is still open, the results prove the importance of pain control in neoplastic diseases, in association to the improvement of patient’s quality of life. Furthermore, according to the primary role played by pain relief in oncology, our commitment is to increment the efficacy of oncological equipe’s intervention (medical doctors, nurses) to perform proper and conscious hospital assistance to neoplastic patients.

D35 PSYCHO-ONCOLOGY: A GLOBAL APPROACH TO ONCOLOGICAL PATIENTS
Gianfranco Porcile, Cristina Bessone, Giulia Pesce, Celeste Grillo
Oncology Department,Alba-Bra Hospital,Alba, (CN)
Since the last years the Department of Oncology of our Sanitary District has organized and offered different modalities of global psychological approach addressed to neoplastic patient. During that period different programs were developed as expression of an integrated perspective of both medical and psychological competences.
In neoplastic patients a multi-professional intervention is required by the psycho-physical natural complexity of individual disease and we need to offer to all family members the possibility of spaces where to compare themselves with the disease, changing of daily habits and the manifold meanings implied. Besides ordinary medical and therapeutic activities, the specific clinical psychological intervention has included four main lines:
• “Self-help Group” open to patients since about 7 years and coordinated by a partially dedicated nurse;
• information and support Group open to patient’s relatives since about 3 years: so-called “ Relatives’s School”;
• supervision with the attending equipe developed in a 2 years time, Balint Group-like;
• a Clinical Psycho-Oncology space (since about 2 years) characterized by:
  1. an individual approach of counselling, support and psychotherapy open to the patient and/or to his family;
  2. therapeutic groups using relaxation and visualization techniques, while patients are receiving chemotherapy in Day Hospital, and art-therapy offered in an only psychological space to favour communication between body and mind.

Our equipe is still working to increase the integration perspective, through moments of comparison and exchange of the different competences and specialities, in order to manage clinical situation on the bio-psycho-social model of disease.
In conclusion only a strict collaboration between medical oncologist and clinical psychologist can obtain the global approach to our neoplastic patients, that is needed for a good compliance of the patients to the therapies and for improve quality of life of the patients and their relatives.

D36 UNCONVENTIONAL TREATMENTS IN CANCER IN ITALY: PRELIMINARY RESULTS
*CRO, Aviano; *ISS Roma
Purpose: In Italy approximately 15% of the general population use complementary/alternative medicine (CAM). This study is aimed at evaluating the effective use of CAM in cancer patients (pts).
Methods: From May 2001 to January 2002, 146 cancer in-patients admitted to the Medical-Oncology Unit of Aviano NCI were asked to answer to a 30-question self-administered survey concerning the use of CAM for their neoplasia. Some of the questions were multiple choice. The survey explored socio-demographical aspects, type and duration of the disease, type of CAM and reasons for using it, degree of satisfaction.
Results: 81 pts were males, median age was 56 years (range 14-81). Education was low in 59.4% of pts, intermediate in 34.6%, and high in 6%. Thirty percent were retired, 20.3% housewives, 17.3% blue-collar workers, 11.3% self-employed, 9.8% employed, 8.3% students, 3% unemployed. Almost all of pts were catholic. Tumor type was as follow: hematological 39%, head and neck 26%, gastro-intestinal 11%, genito-urinary 10.3%, breast 4.8%, others 8.9%. In 54.8% of the sample pts cancer had been present for more than 6 months. Chemotherapy, radiotherapy and surgery had been employed in 92, 37 and 35 pts, respectively, while 38 pts at the time they filled the form had not started any conventional treatment. Fifteen pts declared that they had previously used CAM for purposes other than cancer. CAM had been used by 13 pts for their cancer (8.9%); the most used were herbal and botanical treatments (5 pts), homeopathy (4 pts), diet regimens (3 pts). Their reasons for using CAM for cancer were: to increase the well-being status in 9, to increase chance of cure in 8, concern for the adverse effects of conventional treatments in 6. Physical symptoms and the treatment of cancer were the main target for the assumption of CAM. Seven patients declared to be poorly satisfied with the CAM they had been using. Noteworthy is the fact that 103/146 (70.6%) of the investigated patients would appreciate an interaction between conventional medicine and CAM.
Conclusions: This is the first study examining the use of CAM in the cancer population in Italy. Present results are preliminary and reflect only the situation of a small sample of patients referring to a single cancer center. Therefore, the study is ongoing also in 4 more Centers distributed in different regions of the Italian territory.
Supported by ISS grant n. 99/S74.
D37 THE ROLE OF THE OPERATORS RELATIONAL STYLES PLAY ON THE ONSET/PREVENTION OF EMOTIONAL DISTRESS AND BURN OUT WORKING WITH ONCOLOGICAL PATIENTS

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Operators assisting oncological patients get involved in highly emotional relationships difficult to manage. Many practical questions arise: how and to what extent should operators involve with the patients; what are the emotional risks along the years of work, and to what extent the “relational style” both with the patients and in the operators’ life may favour or prevent the burn out syndrome and the depressive - anxious syndromes. We tried to explore these emotional realms making an assessment on four different teams, accommodated by the relationships with oncological patients, by means of interviews and self reports. The four samples were:

- 50 nurses working in five internal medicine wards, with a high prevalence of oncological and terminal patients
- the nurses of a community palliative care unit
- the nurses of an hospice
- 50 volunteers working within the community palliative care unit

All the samples could be considered as representative of the different realities examined, because over the 85% of each staff took part to the research program. The following areas were assessed with self-reports: the Burn Out Syndrome (Maslach Burn Out Inventory), anxiety and depression (Hospital Anxiety and Depression Scale), the emotional impact of assistance with patients with late prognosis (Work Impact Scale), the operators personal relational styles (Attachment Styles Questionnaire), and the data regarding their working experiences. The interviews were emploved in a non structured manner, to record narrative episodes in order to catch the “experiential atmosphere” underlying the data collected. The volunteers were also administered the Rorschach test. The results suggest interesting findings about the links between the ability to identify emotionally with the patients, tolerating a part of sorrow when they die, and the onset/prevention of burn out on one side and on the operators relational styles on the other side.

We would thank the equipes of F.A.R.O., Busca Hospice, A.N.A.P.A.C.A and A.S.O. S Luigi

D38 PSYCHO-ONCOLOGICAL ACTIVITY AT THE ONCOLOGY UNIT OF SALUZZO HOSPITAL

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On the basis of the need to communicate and discuss problems about both the approach and the emotional distress of the staff, weekly meetings with a psychologist were set up. The psychologist’s collaboration is supported by the Lega Italiana per la lotta contro i Tumori. The following objectives have been reached: 1) the acquaintance of the patients as a person, identifying their psychosocial needs, making the team able to bear the emotional aspects both of the patients and of their family 2) analysis of the emotional aspects related with the communication of the diagnosis and the construction of a therapeutic alliance 3) analysis of the team’s feelings toward the patients and their families and the interprofessional relationship within the attending equipe.

In selected patients were given psychological aid through counselling and individual psychoterapeutic intervention. Apart from the clinical record, in order to consider the patient as a person, the equipe has developed a “Psycho-Social Report” taking into consideration many aspects such as psychological distress, family background, social environment, the patient’s resources and possible risk factors.

More recently a “Reception Setting” has been set up for patients starting chemotherapy where they get to know the oncologist, the psychologist and the professional nurse as a group. This team try to take care of patient and his family, providing psycho-oncological, psychological and social needs. During this phase we try to give the patient, beside technical informations, the basis for a relational dialogue and a personalized assistance.

Our target is to make feel the patient no longer a number or an object, but an active protagonist within the course of treatment.

D39 MULTICENTRIC STUDY ON HOME PARENTERAL NUTRITION (HPN) IN ADVANCED CANCER PATIENTS


* Rete Oncologica Piemonte; * Rete UO dietetica e NC del Piemonte; ° Assessorato alla Sanità; ° Università di Torino; ° A.O. O.Bertetto, ° S.Appiano, ° Giovanni Battista, Torino

Operators assisting oncological patients receving Home Parenteral Nutrition (HPN).

We would thank the equipe of F.A.R.O., Busca Hospice, A.N.A.P.A.C.A and A.S.O. S Luigi.

Results:

- Quality of life improved, remained stable and worsen respectively in 32, 48, 20% of pts.
- Training for voluntary crew in a supportive care programme designated to improve the psychosocial needs of advanced cancer patients.
- The collaboration with home public e ONLUS care service existing in Torino.
- The collaboration with home public e ONLUS care service existing in Turin.
- The training of team with few patients and easier sharing of information between them.
- Saving of money because the sharing of staff with the others services.

D40 DEVELOPMENT OF A PALLIATIVE CARE SERVICE IN A GENERAL HOSPITAL SETTING IN TURIN

G. Ferrero, D. Ottaviani, L. Ciuffreda, B. Ottaviani, M. Castellano, F. Vignotto*, A. De Luca*, A. Musa+, and O. Bertetto


The importance of symptom management is rapidly increasing and expertise in this field is essential for optimising both financial cost effectiveness and medical care. In December 1998, the Staff Management of Azienda Ospedaliera S. Giovanni Battista of Turin deliberated the beginning of Palliative Care Unit (P.C.U.) like a new hospital service for symptoms management of advanced cancer patients.

Objectives:

- Role and interrelationship of the different specialities involved (oncologist, radiotherapist, pain specialist and others)
- Processing of a rational symptom management guide
- Diffuse the palliative culture and master in palliative medicine
- Elucidation of the functions of each medical caregiver, medic in hospital and nurse in home. The professional nurse as a group. This team try to take care of patient and his family, providing psycho-oncological, psychological and social needs. During this phase we try to give the patient, beside technical informations, the basis for a relational dialogue and a personalized assistance.

Our target is to make feel the patient no longer a number or an object, but an active protagonist within the course of treatment.

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- The training of team with few patients and easier sharing of information between them.
- Saving of money because the sharing of staff with the others services.
D41 QUESTIONNAIRE OF PAIN: A NEW INSTRUMENT

The general hospital plays a dominant role in the provision of care for patients all stages of the cancer journey as a large proportion of patients receive their diagnosis of cancer in hospital and almost half of all cancer patients die in a general hospital.

The importance of symptom management is rapidly increasing and expertise in this field is essential for optimising both medical care and financial cost effectiveness.

The objective aim to satisfy the patient's needs: they must simply, easily changeable and short term.

The card processed from us, offers information on the analgesic therapy at the moment of control, on the assumed not conventional therapies from the patient of its will, (music therapy, Bach's flowers, phytotherapy, etc.), and, above all, one exhausting description of the pain, your site and type, a measurement of this, by means of VAS scale.

A series of nine items completes the questionnaire, where the patient describe how much the pain has interfered with the general activity, humour, enables it to work and to walk, the sleep, the taste of living and its social relations.

Currently we have in control 21 patient (16 in advanced cancer, 13 males, 3 females, age range 73-32 years) and we have an increase of this number, encouraged from the aid of this instruments.

In conclusion, it’s generally accepted that the complex physical need of advanced cancer patients are best met by an integrated approach from a multiprofessional team, but we believe that to insert in a medical folder a field dedicated to the symptom pain, its description, treatment and to the consequences of this on the quality of life of the sick one that we have beforehand, is a valid aid in the management to the continuity charitable and the progressive education of the oncologist to consider the general situation of patient and its future management.

D42 TRAINING OF VOLUNTARY SERVICE IN ONCOLOGY AND PALLIATIVE CARE
G.Bersano*, A.Galetto+, G.Ferrero+, C.Nigro+, L.Cuifreda*, and O.Bertetto+
* ANAPACA Torino,+ SAMCO Chiasso, +COES, A.S.O.S Giovanni Battista-Molinetoro.

The cancer is a disease that hits all the person, like biological, psychological, social and spiritual unit. The utility of voluntary in the staff of palliative care and oncology department is sure. But it needs formative programs to be more incessant and efficacious.

A.N.A.P.A.C.A. from 1980 is active in Turin and Piedmont to train many volunteers, frequently in collaboration met by Fondazione Assistenza Ricerca Oncologica (F.A.R.O.), S.A.M.C.O. and many A.S.L.

Recently promote meetings, any month, by experts on ethics, sociology, psychology and psycho-oncology; promote also seminars on communication and its technique.

In A.N.A.P.A.C.A. centre is active any month a cineforum guided by a psychiatrist.

The overall aims of programme were to give volunteer staff the opportunity to:

• Developed their respective role
• Enhance their knowledge
• Explore their attitudes to issues related to palliative care
• Inform and update.

Actually, from 2000, 271 persons were in formation, with a medium age of 40 years, 29%males, 71% females, overall with a high school licence. Objectives:

• Provided psychosocial support to the patient and his family
• Coordinating work with community services
• Developing a core group of volunteers with initiative and skills
• Adapting to changing health and welfare policies.

The knowledge that the oncological sick and its family are protagonist of a total attendance is a good job in the total respect of person.

D43 THE LISTENING CENTER (CDA) OF THE PALLIATIVE CARE OPERATIVE UNIT (UOCP) ANTEA: THE ROLE OF THE NURSE
C.Mastroianni, R. Dobrina, T. Rocchi, S. Frassanito, C. Toboga, M.L. Zavagno, P. Biancolin
Infermiere Uocp Antea, Roma

Antea is a U.O.C.P. that have been assisting terminal cancer patients at home and in a hospice for 15 years. Its organizing model promotes the activity of a call center, a CDA, situated in the hospice indispensable to guarantee a continuous assistance to the patients and their families 24 hours a day.

The CDA service is entirely managed by nurses, who are specifically trained. Objective of the research: verify the role of the nurse in the management of a call center.

Results:
And in 201 calls with the relative’s illness and his role of primary reference’s figure.

Research goal: Specification of the main needs of the caregiver, in connection with the relative’s illness and his role of primary reference’s figure.

Materials and methods: A semi-structured interview has been prepared, and given right after the patient’s charge; through this one, 23 caregivers (1 male and 22 females, with an average age of 51) have been interviewed.

Results: A first analysys, based on the data obtained with the preliminary study, has been focused on the relational need's evaluation; it seems to be satisfied for the most part of caregivers.

73% of the interviewed subjects indeed states to have an adequate social network, and so, as adequate, is judged the familiar network by the 60,9% of the interviewed.

55,6% of those, who judge his familiar network inadequate, furthermore states that the relative’s illness caused uneasiness in relationship with other family members.

Nevertheless, it’s significant observing that 56,5% of the sample states to be alone in looking after the sick relative. Moreover it’s possible to notice that just the 4,3%of those subjects frequents regularly friends, while the rest of the sample frequents friends now and then (47,8%) or never (47,8%).

Conclusions: In spite of the small numbers of the sample and the initial analysys about just one need, the research give another us a clue that confirms the complexity of taking care of a person and the need of a personalised route, that regards more the family contest, in which the patient lives the illness.

D44 CAREGIVER AND HOSPITAL PALLIATIVE CARE
G.Macchi, B.Ottaviani, A.Vespasiano, S.Storto°, M.Demichelis°, M. Torresan and A. De Luca

To take care of an oncological patient’s caregiver, even within the hospital palliative treatments, represent a not negligible quality element of the oncological patient’s assistance.

Research goal: Specification of the main needs of the caregiver, in connection with the relative’s illness and his role of primary reference’s figure.

Materials and methods: A semi-structured interview has been prepared, and given right after the patient’s charge; through this one, 23 caregivers (1 male and 22 females, with an average age of 51) have been interviewed.

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Conclusions: In spite of the small numbers of the sample and the initial analysys about just one need, the research give another us a clue that confirms the complexity of taking care of a person and the need of a personalised route, that regards more the family contest, in which the patient lives the illness.
D45 PSYCHOLOGICAL DISTRESS IN CANCER PATIENTS: SEMANTIC ANALYSIS, IN A STUDY ON DISTRESS AND NEEDS

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Introduction: The objective of this study was to assess, in a group of cancer patients treated in day hospital, the incidence of psychological distress and to try to understand what is the most appropriate term to describe their feeling. Moreover, the major causes of distress and their possible correlation with sex, type of primary tumor and stage of disease have been explored.

Patients and methods: The study group consisted of 306 patients, all on chemotherapy treatment: 43.5% males and 56.5% females, median age 61 years, affected by breast cancer 37.6%, colon 17%, lung 15.35%, other cancers (30%), with metastatic disease (35.8%) or M0 (41.5%). We used the J. Holland’s Brief Screening Tool and Problem List and the Distress Thermometer, to which an application has been added to describe the actual feeling of the patients, choosing among the Italian words: malessere, disagio, difficoltà or none of these terms.

Results: the patients choice of the three terms in the all group was: malessere (45%), disagio (27%), difficoltà (11%) and none (17%). The males/females ratios were: 35/52% malessere, 50/25% disagio, 16/8% difficoltà, 19/15% none; the differences were statistically significant for malessere and difficoltà. The values for M1/M0 pts were: 40/51% malessere, 28/26% disagio, 15/36% difficoltà, 17/17% none. According to the breast/colon/lung tumor location, the corresponding figures were: 48/33/49% for malessere, 30/31/23% for disagio, 7/8/17% for difficoltà, 15/27/11% for none. Among the possible 36 causes, only nausea and alimentary and intestinal disturbances were significantly associated to “malessere”, while hampering in washing and dressing to “difficoltà”. These differences however disappeared when the intensity of these symptoms was analyzed.

Conclusions: It appears from this study that at least 83% of our chemotherapy treated pts may suffer of some kind of psychological distress and no significant differences were observed for different tumors, stages of disease, and sex. Although the choice of malessere was more frequent among females and difficoltà among males, the cumulative data didn’t indicate that the different terms used by our pts do really reflect different meanings or feelings.

Partially supported by Lega per la Lotta contro i Tumori, Trento.

D46 QUALITY MARKERS IN A PALLIATIVE HOME CARE UNIT

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Palliative Home Care Program ASL 3 Genova, Italy

In Italy, at present, more than 150 public and private services, profit and non-profit, supply palliative care to neoplastic patients in advanced/terminal disease status. Up to now the majority of palliative care services made use of quality markers that put in evidence almost exclusively the total activity volume (N° of followed patients, home visits, nurse pertaining interventions, etc) using generic process indicators. The growing interest in Palliative Care (PC) in the Italian oncology panorama requires the use of more specific process and result indicators, able to investigate different quality aspects.

In particular, during 2001, our Oncology Patient Palliative Care Service made use of some indicators in accordance to those proposed by the Italian Society of Palliative Care in 1997, aimed to identify how the service is appropriate, competent and adequate.

Appropriate: the most significant criterion is represented by the reduction of improper admission days, being the indicators represented by the N° of admission days during PC / patient population x 100. The proposed standard value is < 10%; the achieved one is 5.4%. Competent: a sensitive criterion is represented by the stability of home care: the PC must ensure continuity till the last life time. The indicator is represented by the N° of home dead patients who was visited by at least one member of the team during the 24 hours before death / patients population x 100. The proposed standard value is > 90%; the achieved one is 95%. Adequate: the used criterion is the integration with the National Health Care Service and with the General Practitioners (GP’s) The indicator is represented by the number of GP’s who activated the PC service / total number of local health care GPs x 100. The proposed standard is > 50%; the achieved one is 65%.

D47 LOW MOLECULAR WEIGHT HEPARIN (LMWH) THERAPY FOR CANCER PATIENTS (pts) WITH CHRONIC DISEMINATED INTRAVASCULAR COAGULATION (DIC)

Felice Vitali, Giovanna Antonelli, Paolo Colina, Marco Mattina, Domenico Piscio, *Stefano Rotondo, Francesco Ferràu
Division of Medical Oncology and *Internal Medicine, Taormina (Italy)

Diagnosis of chronic dic in late stage cancer pts is often difficult because of lacking of consensus on clinical and laboratory criteria. Borderline or slow lowering platelets count (pc), D-dimer elevation, normal or moderately deranged level of prothrombin time (PT), activated partial thromboplastin time (aPTT), fibrinogen and antithrombin III suggest the diagnosis. Chronic dic can progress to overt acute dic; no clear therapeutic guidelines are defined. Between 05/2000 and 02/2002 15 pts, affected by advanced lung (4), prostate (3), breast (3), ovary (1), gallbladder (1) and colorectal carcinomas, were diagnosed with chronic DIC in our Division (8 males, median age 65 years, range 50-81) and were treated with calcium nadroparin. Coagulopathy-related thrombocytopenia, unrelated to cytotoxic treatment, was assessed as follows: -metastatic cancer, not pretreated with chemotherapy, or last course at least eight weeks before thrombocytopenia diagnosis; -D-dimer elevation; -pc drop observed for at least three consecutive days and not lowering then 20 000/mm3/day; -dihydrogen and antithrombin III levels within or slightly under the normal; -PT and aPTT within the normal range or mildly prolonged; -schizocytosis evidence in the blood samples; -pc rising within 36 hours after the start of heparinization. A first group of nine pts had an initial pc more than 100 000/mmc; a second group of six pts had an initial pc less than 100 000/mmc. Nadroparin was given subcutaneously, 100 U/I/Kg once daily. In the first group of pts, pc normalization was recorded for 8/9, after a median of 5 days, with regard to second group, pc increased over 100 000/mmc but none obtained the full normalization. All the 15 pts remained free from further exacerbation of dic at least for the following six weeks after anticoagulatory therapy, without relevant side effect related to nadroparin. These data, while needing to be confirmed in larger studies, support the effectiveness of calcium nadroparin in improving the chronic dic state in progressive solid cancer, thus preventing the pc decrease and likely delaying the onset of overt dic.

INTRODUCTION

International literature highlighted the raised rate of co-morbity existing between cancer and depression. To give a single example, referring to the entrance into the long tunnel of chronic illness, communication of the diagnosis only marginally coincides with the real acquisition of the awareness of the illness. This involves a process of individual adaptation, of variable duration from person to person. The first results of the research, in collaboration with the Department of Mental Health, are illustrated in this study, which is finalised to measure the whole process and, in particular, the impact of organisational changes on the process itself. The research’s general objectives consist in:

1. evaluating the incidence of psychiatric disturbances;
2. connecting the incidence, the course and the outcome of such conditions by organising the caring services.

METHODS AND TOOLS

Detection of data was carried out during February-March, 2002 and involved all the staff of the Oncologic Team. A new evaluation of other patients will take place in the months of November and December.

Psychological Tests used:

1. Personal Details Form: including a narration of personal family relationships, which are used to give a clear picture for family graphs;
2. Medical Form: describing the history of the illness;
3. Anxiety And Depression (Self-Rating Scale of Zung);

CONCLUSION

One hundred and five patients attending the Oncological day-hospital gave informed consent and took part in the research. Three aspects have thus been studied and correlated, and are here put forward:

1. the phase of the oncological illness;
2. the description of the individual, family and caring context;
3. the patient’s psychic and emotional dimension: the satisfaction perceived and/or the psycho-pathology in course.
D49 AN EFFECTIVE PROPOSAL BY THE PSYCHO-ONCOLOGY UNIT CARING FOR PATIENT WITH UROLOGICAL TUMORS

Patrizia Tempia, Roberta Rossi, Paola Minacapelli

INTRODUCTION
The psychological collaboration in the Interdisciplinary Care Group is developed as follows:
- Focus Group - addressed to patients who have just been diagnosed or operated two or three weeks before. The Group proposes: a) to evaluate and to analyze in depth some caring procedures already operative in the Urology Unit; b) select situations of organizational difficulties to resolve; c) eventually, propose new organizational models which fulfill the expressed needs.
- Psychological Evaluations - requested by the doctors, in situations considered difficult because of disorganization of the emotional state of the patient.
- Psycho Educational Meetings - these are multidisciplinary and offer rehabilitation, informative and emotional elaboration of the experience of illness that the patient is living.
- Psychological Counseling during chemotherapy.

TOOLS
- Monitoring of psychological assistance during the different phases:
  - Qualitative Analysis (Focus Groups, Psycho Educational Meetings);
  - Quantitative Analysis of data tests used:
    - Anxiety And Depression (Self-Rating Scale of Zung)
    - Quality of Life (EORTC - Prostate)
  - Analysis of needs (Need Evaluation Questionnaire of Tamburini)

RESULTS
At the moment two Focus Groups and one Psycho Educational Group have been organized. Such activities have made it possible:
- to improve the integration between the Units of Urology, Oncology and Psycho-oncology;
- to receive useful information on the organizational aspects of assistance;
- to accompany and support the patients during the various stages of their illness;
- to simplify, thus, the relationships between the patients and the Caring Services.

D50 PSYCHOMETRIC PROPERTIES OF THE ITALIAN VERSION OF THE BRIEF FATIGUE INVENTORY

E Maggi, M Costantini, C Bell, M Marchetti, C Broglia, T Catzeddu, C Bighin, I Stevani, R Rosso, M Venturini and L Del Mastro.

Although fatigue occurs in nearly 60-80% of cancer patients, the symptom is rarely assessed and even more rarely treated. Reasons for this may be that the currently available instruments measuring fatigue are time consuming and overly complex for use in the clinical setting. The Brief fatigue Inventory (BFI) (Mendoza T, et al, 1999), a 9 item self-administered questionnaire developed for rapid assessment of fatigue, was translated into Italian using the standard procedures for foreign questionnaires. The psychometric properties of the Italian version of the BFI were evaluated in a study enrolling a consecutive series of adult inpatients and outpatients cancer patients referred to the National Cancer Institute of Genoa and to the S.Matteo Policlinic of Pavia (Italy). The BFI was proposed to 198 patients together with the Medical Outcome Study Quality of Life Short Form (SF 36) - a well-known and validated quality of life questionnaire. For each patient, research staff completed a form with information about the patient, its disease and treatment.

D51 PAIN ASSESSMENT IN CANCER PATIENTS, BASED ON BRIEF PAIN INVENTORY (BPI)


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Purpose: pain is one of the most common symptoms in cancer patients (pts). Pain assessment is essential to achieve a good control of this symptom and several tools may be used for this purpose. Aim of our study was to verify how and in which measure the BPI is applicable in hospitalized pts.

Patients and methods: Among pts hospitalized in our Oncology Unit from January to March 2002, 42 had pain and were requested to fill up the Brief Pain Inventory Italian version (BPI), beginning on the first day of admission and then daily.

Results: BPI was self-administered by 74% of pts while 26% of them did require some nurses help. Sixteen pts were completely aware of their analgesic therapy, 4 pts only partially and 22 were unable to report it. The item of pain relief was filled out correctly by the majority but not all pts (28/42), probably due to some difficulties in understanding the question. Many pts have discontinued to fill out some items or the entire BPI in the following days after the first administration, so the onset, type and duration of pain have been difficult to determine in many cases. Pts who have simultaneously experienced different kinds and localizations of pain, often reported that they had no sufficient tools to explain their pain and it’s impact on their daily activity. Moreover we have observed a decreasing compliance to BPI compilation among pts with longer hospitalization.

Conclusions: in our experience, although all pts have accepted to fill out the BPI, it has resulted in a low applicability in our pts population, suggesting that a more specific and user-friendly questionnaire is needed, at least for our patients.

D52 ONCOLOGIC HOME-CARE: EXPERIENCE OF A CONTINUOUS ASSISTANCE FROM THE L.I.L.T. OF MODENA

Marinella Nasi, Patrizia Giaconabazzi, Elisa Righi, Vincenzo Ariigiano, Monica Morselli, Francesca Zanelli, Gabriele Luppi

Lega Italiana per la Lotta contro i Tumori (L.I.L.T.) - Sezione di Modena

In the last years about 22% of oncologic patients with advanced disease followed by home-care project of our District have been assisted by medical doctors of the local L.I.L.T. section.

In order to assure a continuous assistance, included the time generally warranted by emergengy staff only, from May 1998 we have arranged a service of week-end and night assistance (with the possibility of a direct phone call from patients and their relatives), with a staff of medical doctors with experience in palliative care. The aim is to reduce the number of urgent hospitalization, useless for this kind of patients, and to avoid deaths in hospital.

The L.I.L.T. office represents the place where this equipe discuss about their experience on every single case. From May 1998 to December 2001, 574 home visits have been made on a total of 279 patients followed by the L.I.L.T. (for a total of 15624 days, average 56 days/patient).

The main reasons of urgent visits were: pain (39%), dyspnoea (19%), fever (9%), anxiety (11%), vomiting (10%), death (6%), anuria (4%), hemorrhage (2%). The most commonly used therapies were: analgesics, diuretics, cortisone, anti-emetics and anxiolytics. Fifteen cases (5.3%) needed hospitalization. This service met a good acceptance of both patients and relatives, as shown by the high number of phone advices (1500).

The availability of medical doctors with experience in care of oncologic patients with advanced disease, whose presence is assured at any time, is an useful aid for patients and their families; it can improve their quality of life. Besides, it avoids useless hospitalization and increases the percentage of patients dying at home.

On the ground of this positive experience a plan is going to realize to extend this service to every patient followed by the oncologic home-care, based on a strict collaboration between medical staff of the L.I.L.T., family doctors and nurses.
Complementary and alternative medicine (CAM) is defined as therapies used by terminally ill neoplastic patients. This type of therapy has permitted a palliation of symptoms and a good death in many patients. In our patients, the sole therapy of CAM lived on average 16 months, in comparison with 12 months reported in the literature. In 425 patients, Karnofsky Performance Status (KPS) was between 40 and 60. Some difficulties have arisen to interpret data pertinent to the management of symptoms, since the evaluation of symptoms didn’t suppose a quantitative codification and it depends by sanitary operator’s subjectivity.

On this ground the Multidisciplinary Group felt the need, since February 2002, to add to the evaluation the Therapy Impact Questionnaire as a codified instrument to compare data of symptoms and quality of life without forgetting the will to protect suffering patients.

### D53 MULTIDISCIPLINARY APPROACH IN PALLIATIVE CARE: OUR EXPERIENCES

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The collaboration among various specialists of ASO San Giovanni Battista of Turin permitted the implementation of a Multidisciplinary Group, directed by Pain Therapy and Palliative Care Unit(PCU), for treatment of oncological patients.

The group’s end-point is the evaluation for best care support, specialised and personalised to each patient of PCU. This evaluation is carried out by oncologists, pain specialists, psychologists, nurses and other medical specialists.

A special clinical document has been elaborated to record patients’ data. It consists in:
- a semi-structured interview performed by psychologists and nurses at the moment of first visit to individualize how the patient lives the illness and his expectation on treatments
- a document of general clinical evaluation
- a nursing schedule
- the documents for different specialists.

**Results:** the PCU followed 118 patients since 1999. All patients were evaluated by oncologist, pain specialist and psychologist. The dietician examined 39 patients, the patients, the radiotherapist 31 %, the orthopaedic 22 %, the physicist 9%); the surgeon 8,7% and others specialists (neurologist, geriatrician, dermatologist and social and spiritual assistants) a percent between 1 % and 6 %. Some difficulties have arisen to interpret data pertinent to the management of symptoms, since the evaluation of symptoms didn’t suppose a quantitative codification and it depends by sanitary operator’s subjectivity.

On this ground the Multidisciplinary Group felt the need, since February 2002, to add to the evaluation the Therapy Impact Questionnaire as a codified instrument to compare data of symptoms and quality of life without forgetting the will to protect suffering patients.

### D54 THE CRUCIAL ROLE OF A DETAILED INFORMATION IN CANCER PATIENTS UNDERGOING HIGH-DOSE CHEMOTHERAPY AND AUTOLOGOUS STEM CELL TRANSPLANTATION

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**Introduction** - The psychological assessment of cancer patients undergoing high-dose chemotherapy (HDCT) and autologous stem cell transplantation (SCT) play an important role during the preparation to the procedure.

**Patients and methods** - The study was conducted on 81 patients who both solid and hematologic tumors (Breast cancer, Non-Hodgkin Lymphoma, Hodgkin Disease, Multiple Myeloma and Amyloidosis), treated during the last three years at our institution. The psychological assessment was performed before patient’s enrollment, at the preliminary visit before hospitalization, two times during the therapeutic program and at the discharge from hospital.

**Results/Conclusions** - Conditions of stress, deprivation and social discomfort connected with the isolation during the phase of myelosuppression post-transplant, combined with the anxiety related to the possible outcome of the specific disease, represent a very important risk factor for patients. In both cases the patient has already experienced such conditions (as in the case of multiple transplants approach), the situation of the protected environment can contribute to involve the “fear of the unknown” and the “fear of the result”. Moreover, a not correct and effective information by the medical and nurses staff can stimulate this risk as well as that of the exacerbation of more complex psychosomatic disorders (ICO. 30: 1907-1917, 2002). In this field, with an appropriate psychological approach, can be of help: 1) contextualizing the signs and symptoms of the disease and 2) clarifying the aspects of the fantasies related to the ongoing treatment.

In our experience, with a adequate support (and irrespective to the type of cancer), patients experience equally positive and negative emotions. We conclude that, in the specific field of HDCT + SCT, a multidisciplinary approach to the communication and a planned psychological support is crucial for the possible outcome of the therapeutic plan.

### D55 THE ONCOLOGIC HOME CARE IN NAPLES: QUALITY CONTROL

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Since 1992, “La Lega Italiana per la Lotta contro i Tumori di Napoli” has been carrying out an oncologic home care programme based on an appropriate welfare, experimental and reproductive pattern, which has as target the improvement of the quality of life of oncologic patients in advanced stage, the support of family, the optimization of organizing human and economic resources. The programme which is entirely free for the patient includes: weekly oncologic medical examinations, meetings with the psychologist, oncologists, pain specialists, psychologists, nurses and other medical specialists. Since 1992 to nowadays, 1340 oncologic terminally ill patients have been treated at home, with life expectation less than six months. Median age has been 62 (range 16-89). For all the patients coming into our services it has been compiled a structured questionnaire was submitted to 46 patients during chemotherapy from 2000/2002 to 15/30/2002. The population was: 24 F, 22 M, median age 64 yrs, 26 gastrointestinal cancers, 14 breast cancers, 6 others (1 HNSCC, 1 uterus, 2 ovarian, 2 lung). Relation between variables were assessed by the $\chi^2$ test with statically significant $p$ value inferior or equal to 0.05.

**Results:** 11/46 (23.8%) patients used CAM: 2 of them employed several type of CAM. The CAM used are so defined: 2 pts “special diet”, 3 pts “homeopathy medicine”, 6 pts “drugs with aloes”, 1 pt “other herbal therapy”, 1 pt “meditation”, 1 pt “psychological therapy”. Patients didn’t answer for motivation in using CAM. The 7 responders explain their motivation for using them and to compare the characteristic of CAM users and CAM nonusers (sociodemographic, medical characteristic, attitude).

**Patients and methods** - a structured questionnaire was submitted to 46 patients receiving conventional medical therapy (chemotherapy and/or supportive care) also use CAM, to assess which CAM is the most popular, to assess patients’ motivation for using them and to compare the characteristic of CAM users and CAM nonusers (sociodemographic, medical characteristic, attitude).

**Conclusions** - CAM is common in our neoplastic population, with a frequency paralleling reported data. CAM is thought useful to improve the quality of life and cure of cancer, therefore it may influence positively the humour.

Given the numbers of patients combining CAM with chemotherapy, the oncology community must increase communication and information to patients about this problem.

### D56 COMPLEMENTARY AND ALTERNATIVE MEDICINE IN CLINICAL ONCOLOGY: WHAT HAPPENS?

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**Introduction** - Complementary and alternative medicine (CAM) is defined as the diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole, by satisfying a demand not met by orthodox or by diversifying the conceptual frameworks of medicine” (Kelsen et al, 2002). CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being.

**Objectives** - to determine what proportion of our cancer patients receiving conventional medical therapy (chemotherapy and/or supportive care) also use CAM, to assess which CAM is the most popular, to assess patients’ motivation for using them and to compare the characteristic of CAM users and CAM nonusers (sociodemographic, medical characteristic, attitude).

**Patients and methods** - a structured questionnaire was submitted to 46 patients receiving conventional medical therapy (chemotherapy and/or supportive care) also use CAM, to assess which CAM is the most popular, to assess patients’ motivation for using them and to compare the characteristic of CAM users and CAM nonusers (sociodemographic, medical characteristic, attitude).

**Conclusions** - CAM is common in our neoplastic population, with a frequency paralleling reported data. CAM is thought useful to improve the quality of life and cure of cancer, therefore it may influence positively the humour.

Given the numbers of patients combining CAM with chemotherapy, the oncology community must increase communication and information to patients about this problem.
**Session D: Palliative and Supportive Care**

### D57 PREVENTION OF DELAYED EMESIS DUE TO MODERATELY AND HIGHLY EMETOGENIC CHEMOTHERAPY: SUPERIORITY OF TWICE DAILY VS ONCE DAILY ORAL METHYLPREDNISOLONE IN COMBINATION WITH ONDANSETRON


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Combination of a serotonin receptor antagonist and a corticosteroid results in excellent prevention of emesis for the majority of patients receiving moderate-high emetogenic chemotherapy. However, still the optimal doses and schedule have not been determined. The aim of this study was to evaluate two different schedules of an oral antiemetic regimen sequentially to the same patient after the first and second cycle of moderately or highly emetogenic chemotherapy, defined as level 3, 4 or 5 according to Hesketh et al., JCO 1997.

Eighty-seven consecutive chemotherapy na"ıve patients received oral ondansetron 8 mg bid + methylprednisolone 32 mg given as a single morning dose (schedule A) on days 1-4 of the first cycle of chemotherapy, and ondansetron 8 mg bid + methylprednisolone 16 mg bid (schedule B) on days 1-4 of the second cycle. Patients were asked to complete a diary over the seven days following each chemotherapy.

Study population consisted of 14 males and 73 females, with a median age of 56 years (range 32-75); 62 and 25 patients respectively received moderately and highly emetogenic regimens. There was a significantly lower incidence of nausea per patient treated during fractionated regimen (54%) as compared to those receiving the once daily schedule (65%), p = 0.03. The incidence of vomiting, constipation, headache, loss of appetite, dyspepsia, epigastric pain, hot flushes, bicipus, and diarrhea was similar for the two treatments. In conclusion, the fractionated schedule (schedule B) seems to be more effective in preventing delayed nausea, suggesting that a twice daily corticosteroid may be superior to a single daily dose. A randomized blinded trial comparing these two schedules will be started by our group based upon these results.

### D59 A PSYCHOEDUCATIONAL INTERVENTION FOR WOMEN WITH BREAST CANCER AND GYNECOLOGICAL TUMOURS


The present study represents a multicentric experience realised in Italy to experiment a psychoeducational intervention on women affected by breast cancer and gynecological tumours.

**Purpose:** The aim of the study is to evaluate the short and long term effects of a 7-week psychoeducational group intervention on psychological distress, coping methods and perceived social support. This research design foresees a psychological assessment before the psychoeducational intervention (T0), immediately after, at 7 weeks (T1), and 6 months later (T2). The sample consists of 18 women (mean age: 50,9; range: 27-65), 10 of them affected by breast cancer and 8 by gynecological tumours. Selection criteria were: a) early diagnosis; b) good prognosis; c) no psychiatric disturbances; d) good quality of life; e) no severe complications; f) no current use of antipsychotic medication.

**Methods:** The instruments used are: 1) the POMS (Profile of Mood State), 2) the MAC (Mental Adjustment to Cancer), and 3) the MSPSS (Multidimensional Scale of Perceived Social Support).

**Results:** Immediately after the 7 week intervention (T1) the POMS scores indicate a significant decrease of anxiety (P=0.003), depression (P=0.03), anger (P=0.0094), fatigue (P=0.001), confusion (P=0.003) and of the total mood disturbance index (P=0.0009). The MAC and the MSPSS scores don’t present significant changes. Six months later (T2), the POMS scores continue to be lower than the baseline values but they are not statistically significant, with the exception of the tension (P=0.0328). Regarding the MAC questionnaire, the analysis finds a significant change of the anxious preoccupation (P=0.0125), that results lower than the baseline score. The MSPSS scores don’t present remarkable data.

**Conclusions:** These results indicate that the psychoeducational intervention reduced psychological distress in short term; in long term the efficacy is confirmed by the decrease of the tension and the anxious preoccupation.

### D58 A DISCHARGE PLANNING FOR CANCER PATIENTS IN TRANSITION FROM HOSPITAL TO HOME OR HOSPICE FOR PALLIATIVE CARE


The transition from being an inpatient at hospital to outpatient needing home care, is often viewed as a change, which generates stress for patient and his family. To minimize this stress, avoiding care will become fragmented, we realized a discharge planning based on a concept of the continuum of care through an integrated relationship between inpatient and outpatient care. In March 2000 started at the Department of Oncology at Fatebenefratelli-Tiberina Island Hospital, in collaboration with Palliative Care Service-ANTEA hospice an experimental program of transition through hospital to home care, rehabilitation and/or palliative care. This program was planned through a coordinated and integrated approach as following:

1. an integrated clinico-prognostic evaluation of the patient and disease status by inpatient and outpatient team;
2. evaluation of psychosocial assessment of patient and his family;
3. common and coordinated decision about palliative treatment and planning discharge, without fragmentation and disorganization.

The aim of this program for cancer patient in pre-terminal and terminal phase of disease is to minimize the stress of fragmented care and to ensure the best assistance and quality of life at patient and his family. From March 2000 to March 2002 253 patients were enrolled in this protocol of which 131 patients followed at home care, and 25 at Hospice. 2269 days were delivered at home care and 253 days at Hospice for a median of days/patient of 48.27 days at home, and 14 days at Hospice, respectively.

Preliminary results of this experience demonstrate that it’s possible a good integration between inpatient and outpatient team, aimed to offer a good patient care, also in a critical and crucial phase of disease. The next step of the study will be to evaluate the satisfaction of patients and family and/or caregiver about this model of assistance.

### D60 THE INTERMEDIATE PHASE: A CRITICAL PASSAGE FROM ACTIVE CURE TO PALLIATIVE CARE. AN ATTEMPT TO MANAGE A DIFFICULT MOMENT FOR PATIENTS AND FAMILY AND AN EXPERIENCE FOR A GLOBAL ASSISTANCE OF THE ONCOLOGICAL DISEASE


In the pts with advanced or metastasic cancer there is a critical phase which leads from active cures to palliative cares. At this moment we record a progression of the disease, an increase of the symptoms, a worsening of the general condition under psychological and physical point of view. The question is: should we try another line of CT or should we get to the palliative care? At this moment it is easy to record a discrepancy between the request of the pt (and the family) to be cured and the tendency of the Oncologist to interrupt the active therapy. Often the pts feel to be abandoned. But the PS is often not so bad and the home assistance cannot be started. Depression, sadness and escape toward alternative therapies are very common in this phase. We christianized this moment the Intermediate Phase (IP) and tried to answer to the patient need starting an experience of ambulatory and DH care. From July 2001 until now we started a mixed ambulatory/DH service in order to guarantee a continuous care to our pts. The service has been organized as follows: weekly or fortnight ambulatory visits; ambulatory for acute problems at request (after phone contact); supportive care in DH structures. One Physician and one Professional Nurse are devoted for this project. Psychologist comes for specific problems. Till now 63 pts have been followed in ambulatory. 42 pts received supportive care in DH. 105 programmed visits and 37 urgent consultations were performed. At present median time of taken care in hospital is 9.5 weeks. 36 pts were taken in care by home assistance. 30 of them already died. Only 5 pts needed more intensive care and were admitted into the ward. Unfortunately no QoL or preference questionnaire were performed, but no pt was lost to follow up and we believe that this is a sign of agreement for the project.

The Intermediate Phase is a very difficult moment which leads to the terminal phase. A continuous global assistance guaranteed from a specific team skilled in palliative care seems to be highly appreciated by patients and families.
Introduction: Anemia is a negative prognostic factor for tumors treated with chemo-radiation therapy, and demonstrate a close relationship between HB level, fatigue and QoL. The best HB target in these papers was 13-14 g/dL. The mean rate of HB increase was 3.4g/dl (1.8-5.0 g/dl) during the study, to a final value of 13.0 (11.2-14.8 g/dl). The mean rate of HB increase after 2 wks of induction treatment was 1.14 g/dl (0.20-2.6 g/L, CI95 0.62-1.66) and 1.3 g/dl during the maintenance treatment (0.26-2.6 g/L, CI95 0.84-1.74). In pts with HB 10.1-11.5 g/dl (mean 10.9) were given r-HuEPO before starting RT. Mean HB increase was 3.4/dl (1.8-5.0 g/dl) during the study, to a final value of 13.3-15.1 g/dl (mean 14.5). The mean rate of HB increase was 1 g/dl (0.15-1.70 g/dl) after 2 wks of induction treatment and 1.3 g/dl (0.26-2.90 g/dl) over the maintenance treatment period. Mean scores in QoL for all pts evaluated increased 36 mm (CI95 31-41) for energy level, 34 mm (CI 95 28-40) for ability to do daily activities, and 49 mm (CI 32-56) for overall quality of life. In QoL, pts increased 36 mm (CI95 31-41) for energy level, 34 mm (CI 95 28-40) for ability to do daily activities, and 49 mm (CI 32-56) for overall quality of life.

Primary endpoint was QoL, second one to improve the cellular hypoxia for chemo-radiation therapy, and demonstrate a close relationship between HB level, fatigue and QoL. The best HB target in these papers was 13-14 g/dL. The mean rate of HB increase was 3.4g/dl (1.8-5.0 g/dl) during the study, to a final value of 13.0 (11.2-14.8 g/dl). The mean rate of HB increase after 2 wks of induction treatment was 1.14 g/dl (0.20-2.6 g/L, CI95 0.62-1.66) and 1.3 g/dl during the maintenance treatment (0.26-2.6 g/L, CI95 0.84-1.74). In pts with HB 10.1-11.5 g/dl (mean 10.9) were given r-HuEPO before starting RT. Mean HB increase was 3.4/dl (1.8-5.0 g/dl) during the study, to a final value of 13.3-15.1 g/dl (mean 14.5). The mean rate of HB increase was 1 g/dl (0.15-1.70 g/dl) after 2 wks of induction treatment and 1.3 g/dl (0.26-2.90 g/dl) over the maintenance treatment period. Mean scores in QoL for all pts evaluated increased 36 mm (CI95 31-41) for energy level, 34 mm (CI 95 28-40) for ability to do daily activities, and 49 mm (CI 32-56) for overall quality of life. In QoL, pts increased 36 mm (CI95 31-41) for energy level, 34 mm (CI 95 28-40) for ability to do daily activities, and 49 mm (CI 32-56) for overall quality of life.

Conclusions: These pilot survey clearly shows that CAM use is common among cancer patients. Supported by these results, we intend to extend the research to a larger population because it is our conviction that if oncologists ask about the reaction of the medical and nursing team about CAM use, it will be more important to get a better understanding of the experience of the patients. When we compared the use of CAM between the four groups (sex, stage of disease and hospital), we found significant differences between the groups. Among the latter, the major part (88%) revealed to be interested in receiving more information about CAM. A relevant difference between two groups was the education level: better educated people were more represented in the first group. More famous and used CAM were omeopathy (70%) and fitotherapy (85%) (especially the use of Aloe Vera). Interestingly many patients cited Di Bella (20%) as the most important and most important source to obtain a better experience of treatment. It appears from our data, that the diagnosis of cancer itself is the base of pts need of more informations about their future. On the other hand both males and females highly expressed the need of more informations on their future.

Partially supported by Lega per la Lotta contro i Tumori, Trento.
**D65 THE DOCTOR-PATIENT RELATIONSHIP: NEED OF SINCERITY OR NEED OF REASSURANCE OR BOTH?**

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**Introduction**: Objective of this study was to evaluate and correlate the need of sincerity from the doctor and from the family, among pts on chemotherapeutic treatment in Day Hospital, receiving a self administered questionnaire.

**Methods**: The Needs Evaluation Questionnaire (NEQ) was administered to 306 cancer pts: 43.5% males and 56.5% females, median age 61 years, 58.5% M1 and 41.5% M0, affected by breast cancer (37.6%), colon (17%), lung (15.35%) and other cancers (30%). Patients were asked to answer, among others, the following questions: I need the doctors be more sincere with me. I need to be more reassured by the doctors. I need to be more reassured by my relatives.

**Results**: Concerning the first 2 questions, 57% of the pts required more sincerity from the doctors, and 47% to be more reassured. A statistically significant correlation was found between the need of more sincere doctors and the need of greater reassurances from doctors, with 22% of the pts expressing both needs, 48% none, 5% requiring more sincerity but not to be reassured, and 25% the opposite. On the other hand 66% of the pts, didn’t express the need of more sincere doctors and greater reassurances from the family and only 9% both, while 17% required more sincere doctors but not family reassurances and 8% the opposite and this correlation was statistically significant. Looking at the need of more reassurances from the doctor compared to that from the family, again the correlation was significant, with 13% of pts expressing both needs, 34% the reassurance from the doctors only, 4% from the family only and 49% none.

**Conclusion**: It appears from our data that most of the cancer pts need a closer relationship with their doctor, and require more sincerity but, at the same time, to be also reassured. The doctor’s reassurance is highly preferred, compared to that from the family. This is particularly true for M1 pts who expressed a statistically significant greater need of more sincerity and reassurance from the doctor as well as from the doctor and the family, compared to M0 pts. These data should be considered in the every day practice, to understand what really expect some pts from the doctors with the disclosure of the truth.

**Partially supported by Lega per la Lotta contro i Tumori, Trento.**

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**D66 BURNOUT OF NURSES WORKING IN A MEDICAL ONCOLOGY DIVISION: RECOGNITION AND REMEDIATION STRATEGIES**

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**Introduction**: Oncology nursing is associated with highly stressful and emotional situations. The stress sources for the nurses depend on continuous closeness with death and dying, on sense of inadequacy towards the war against disease, on emotional involvement with patients and families and on imbalance among work, outside life and individual resources. These factors contribute mostly to the genesis of burnout syndrome. The aim of this ongoing study is to evaluate work history, stress and burnout variables among care nurses employed in the oncology division before and after a specific psychological support program.

**Methods**: Demographic and work survey, rapid self-assessment rating scale for the subjective measurements of perceived stress (SRE by Bondi and Tarstiani questionnaire) and Maslach Burnout Inventory were evaluated. Absenteeism from work and demand for department transfer were also considered. A nurse meeting with the psychiatrist trainer was regularly scheduled each two weeks.

**A cognitive/constructivist perspective was carried out.**

**Results**: We analysed 22 nurses aged 35-72 y, M/F ratio 6.3, married/unmarried ratio 2.3, hospital and specific medical oncology length of service were respectively 11.426 and 5.432 y. A low-middle stress level and a low burnout level were pointed out at the beginning of the course.

**Conclusion**: The project is performed in order to allow free and open discussion of critical problems that can lead to burnout. It encourages communication among colleagues and supports the sharing of high-perceived stress as well as morality and values. The present proposal met general approval; all nurses experienced a lack of tension in the work. The indexes above reported will be reassessed after 9 months from the beginning of the project together with a patients and relatives satisfaction questionnaire.

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**D67 THE APPROACH TO DYING PERSON IN A GENERAL HOSPITAL**


The multidisciplinary group for palliative care in ASO San Giovanni Battista of Turin has formed a discussion group on the theme of “dying in Hospital”.

**Primary end-point** is the description of dying management and its practical and emotional aspects.

**Methods**: A semi-structured interview has been elaborated and 18 sanitary operators (10 physicians, 6 nurses and 2 other figures for medical care) have been interviewed in oncological and surgical units. The interview investigates:

- the unit’s norms about dying management
- the emotional aspects of this event
- the presence of a dedicated room
- the sanitary operators’ behaviours
- the knowledge of charter of dying person’s rights.

**Results**: A first analysis has been focused on the data concerning the knowledge of charter of dying person’s rights.

- The most part of operators (88.9%) don’t know the charter.
- All interviewed assert that the dying patients have always received information about their clinical conditions, but for 44.4% of operators these information often are not truthful.
- For 50% of interviewed the dying persons have shared in therapeutic decisions, but 72% assert that the place of care is decided by relatives.
- 88.9% affirm that the relief from pain has been guaranteed for the most part of the operators (10 physicians, 6 nurses and 2 other figures for medical care) have

**Conclusion**: The project is performed in order to allow free and open discussion of critical problems that can lead to burnout. It encourages communication among colleagues and supports the sharing of high-perceived stress as well as morality and values. The present proposal met general approval; all nurses experienced a lack of tension in the work. The indexes above reported will be reassessed after 9 months from the beginning of the project together with a patients and relatives satisfaction questionnaire.

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**D68 QUALITY OF LIFE ASSESSMENT IN CONTROLLED CLINICAL TRIALS. A CRITICAL REVIEW OF LITERATURE**

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**Dep of Oncology, City Hospital Rimini.**

Introduction. Although quality of life (QoL) represents one of the main outcomes in clinical oncology, and many trials report data regarding QoL during treatments for neoplastic diseases, QoL assessment still remains a misexplored field both by a clinical and a methodological point of view. We report our preliminary data of a methodological review of literature on randomized clinical trials regarding QoL.

**Methods**: All the randomized clinical trials reporting data about QoL were reviewed and included into the analysis. All the selected trials were classified into three groups according to QoL relevance as end point of the trial (Primary (P), Important but Not-Primary (INP), Secondary (S)), and only the former ones were analyzed.

**Results**: 125 randomized clinical trials in oncology were identified and selected as relevant between 1980 and 2001, and 89 (71.2%) were considered eligible and included into the analysis. 13 (14.6%), 46 (51.7) and 30 (33.7) trials were respectively classified in the group P, INP, and S. 7 out of the 13 P trials (53.8%) were conducted in advanced setting and 6 (46.2%) in the adjuvant one; a validated tool in evaluating QoL was used in 10 trials (76.9%), and a not-validated one was used in the other 3 ones. An overall number of 3516 patients were analyzed in the 13 P trials, with a median number of enrolled patients/trial of 74 (range 28-1320) and only 6 trials (46.2%) with more than 150 enrolled patients. The median overall quality score was 75% (range 36.4% and 100%) with a statistical significative correlation with the year of publication (p=0.000), the setting (p=0.007) and the state of the biological mechanisms in the patients (p=0.000). The value. It is to be hoped that in the near future a new way of planning randomized clinical trials could overcome the methodological limits we met in our literature review to obtain new and methodological-correct data about QoL.

**Supported by IOR.**
D60* ORGANIZATIONAL ASPECTS OF PALLIATIVE HOME CARE

Ferdinando Garetto, Alessandro Valle, Antonella Re, Oscar Bertetto

There are several important aspects to be taken into consideration when providing home health care. The Fondazione FARO Onlus team who have provided home care in Turin since 1989 presents some points to consider regarding the organizational aspects of home care.

Service integration

The home care team is, in general, chronologically the “last in line” regarding patients’ disease history. It is necessary to enter in gradual stages to set up a relationship of reciprocal trust and to respect cares given by previous sources. It is also important that the home care team is aware of their responsibilities towards the patient. There are particular situations in which necessary therapies / or instrumental researches cannot be carried out at home (radiotherapy, implants, surgery), thus integration with these services is advisable, preferably via defined means.

Clinical and Therapeutic Aspects

The neoplastic history must be known to avoid excess or insufficient care. Home therapy must be provided according to the palliative care principles that privilege simple and efficient drug dosages, way and time of administration. In terminal stages, a patient may often “inherit” therapies from the previous stages of disease. Revaluing, re-proportioning, or suspending therapy, is possibly necessary, although it requires skill and relational capacities.

Technical and organizational aspects

Home care management of parenteral therapies, central venous catheters, medications, hygiene must be carefully evaluated. A specific team programme is necessary to adequately involve and support the family. It is important to know how to simplify without losing quality and efficiency.

Environmental and relational aspects

Palliative care is aimed to the patient and as a consequence to his family. In planning assistance, the resources, and limits in the home situation must be carefully evaluated. The family must be guarantee a minimum effective planning assistance, the resources, and limits in the home situation must be defined means.

Services’ integration

There are several important aspects to be taken into consideration when providing home health care. The Fondazione FARO Onlus team who have provided home care in Turin since 1989 presents some points to consider regarding the organizational aspects of home care.

Session D: Palliative and Supportive Care

D70* PSYCHOLOGICAL AND PHYSICAL SUPPORT PROGRAMME IN BREAST CANCER PATIENTS (PTS) AFTER SURGERY: PRELIMINARY RESULTS

L. Bonetti, M. Cazzaniga, M. Cremosoni, M. Mandalà, N. Ventura* and S. Barzi
Medical Oncology, *Rehabilitation Unit

Breast cancer is a very distressing event in a woman’s life. In June 2000 we started a multidisciplinary, comprehensive programme aimed at the psychological and physical recovery of breast cancer pts after surgery. During the first visit with the oncologist, pts were invited to meet a psychologist. They discussed their working activity, life style, affectivity, sexuality, social relations, coping and the feeling of their own body and were hence invited to participate in the rehabilitations groups. During the first group meeting, the pts underwent COPE and BDI tests to obtain a baseline psychological evaluation. In order to evaluate general Performance Status one year after surgery, the pts redid the COPE and BDI tests and had a further meeting with the psychologist. Till now, 21 pts had a complete follow-up. Median age was 48 years (34-61), 15 pts underwent mastectomy, 6 pts quadrantectomy, 8 pts received chemotherapy (CHT) which caused alopecia, 5 pts CHT without alopecia, and 8 pts received hormonal treatment. Results are reported in the table below:

<table>
<thead>
<tr>
<th>LIFE STYLE EVALUATION</th>
<th>BASELINE (pts)</th>
<th>+ 1 YEAR (pts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping disturbance</td>
<td>19/21</td>
<td>15/21</td>
</tr>
<tr>
<td>Active coping</td>
<td>7/21</td>
<td>18/21</td>
</tr>
<tr>
<td>Reduction in social activities</td>
<td>12/21</td>
<td>2/21</td>
</tr>
<tr>
<td>Reduction in own hobbies</td>
<td>12/21</td>
<td>4/21</td>
</tr>
<tr>
<td>Body conflict</td>
<td>19/21</td>
<td>4/21</td>
</tr>
<tr>
<td>DISEASE AWARENESS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partially aware</td>
<td>7/21</td>
<td>0/21</td>
</tr>
<tr>
<td>Completely aware</td>
<td>14/21</td>
<td>23/21</td>
</tr>
</tbody>
</table>

Two pts out of 8 who were working at the time of surgery decided to retire. A 3 pts who were housewives before surgery were still housewives one year later. Three pts (1 mastectomy and 2 lumpectomy) still had a conflict with their body. All pts regarded positively this comprehensive, multidisciplinary program as an opportunity to face and discuss their oncological disease and its consequences.

D71* USE OF ANALGESICS IN PATIENTS WITH ADVANCED NON-SMALL-CELL LUNG CANCER (NSCLC)

Clinical Trials Office, National Cancer Institute of Naples, Italy

Introduction and objectives. Pain is among the most frequent symptoms of cancer, and the optimal use of analgesics (AN) is an important goal in the supportive care of these patients. Aim of this study is to determine the use of analgesics in patients with advanced NSCLC and to evaluate whether chemotherapy, patients performance status (PS) and age do affect type of AN.

Methods. Data of patients enrolled in 3 randomized trials of first line chemotherapy were analyzed. The ELVIS study (1996-1998) compared vinorelbine (V) with supportive care in patients <70yrs. The MILES study (1998-2000), compared gemcitabine + vinorelbine (GV) with V and G in patients ≥70yrs. The MILES study (1999-2001), compared cisplatin-based (PG or PV) with GV, in patients <70yrs. AN was classified according to the WHO ATC system. Quantitative analysis of AN consumption was performed converting the daily dose of each drug in morphine-equivalent milligrams (Meq-mg). Analysis was limited to the period of time covering the first 3 cycles of chemotherapy.

Results. Overall 341 (31%) patients required AN; these corresponded to the lower WHO analgesic scale step in 147(45%), the intermediate in 180 (48%) and the higher in 44 (12%). There were no significant differences in the amount of AN comparing pts who received chemotherapy (V) or supportive care alone (data from the ELVIS study) and comparing P- versus GV- based AN (data from the MILES study). AN effect was studied in the whole group of 1185 patients. PS2 patients received, on average, a higher amount of AN, with a mean daily AN consumption of 36.4 vs 23.8 Meq-mg in PS 1 and PS 0-1 patients respectively. AN was classified according to the WHO ATC system. Quantitative analysis of AN consumption in advanced NSCLC patients with advanced NSCLC need analgesics. The use of strong opioids (WHO higher step) is extremely rare. A worse Performance Status at the time of diagnosis is correlated with a greater need and the assumption of a higher amount of analgesics. Age (≥70 vs <70), chemotherapy with vinorelbine, and cisplatin-based chemotherapy do not affect the amount of analgesics.

Partially supported by APRIC-CTPG.

D70* ONCOLOGIC EMERGENCIES: CRITICAL ASSESSING OF UROHEMIOLOGICAL AND PREVISION OF EFFICIENT COMPREHENSIVE CARE

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Oncologic Emergencies (OE) are a well identified chapter in Clinical Oncology, distinguished in medical and surgical problems. Unfortunately very few publications have evaluated the real impact of OE on health care delivery. Our study, started in ’99 and still going on, had these end-points: a) the epidemiological evaluation of OE and other urgent problems, b) the impact of OE on health care delivery, c) how are managed by doctors of Emergency Department (ED) and Medical Oncologists, d) the outcomes of the interventions, e) possible suggestions in health care organisation regarding OE. Two different populations of pts were identified: those visited in ED and those in the emergency ambulatory in Oncology Dept. In ED we recorded 830 admissions for OE (over 77763 total admissions). Most common cancers were: lung (105), breast (105), colon (104), prostate (92), others (424). Disease was metastatic in 86% of pts. The common causes of admission: pain (18%), urinary bleeding or obstruction (12%), dyspnea (12%), GI hemorrhage (10%). Management solutions: discharge without home assistance (48%), admission in wards (52%). Oncologists were consulted only in 18% of cases. The ambulatory for emergency in Turin Dept, recorded 2214 Adhome. Breast cancer (30%), colon (26%), lung (16%) and surcomas (12%) were the most common cancer subtypes. 89% of the patients were metastatic. The reasons for urgent visit were: cachexia and bad PS (56%), CT toxicity (11.2%), anemia (8.8%), ascite (8.2%). Clinical decisions: 30% of the pts were admitted, 50% entered in DH for supportive care; 20% discharged at home in continuous assistance. 50% of admitted pts died in the Oncological ward for disease progression after a median time of 5 days. Conclusions: in our experience “classical” OE are seldom cause of admission, while pain and bad PS ECOG are the most frequent causes. Continuous home assistance decreases the rate of request of acute intervention or admission. Strict co-operation between Practitioner, ED and Oncologist is needed. A specific ambulatory for urgent problems into Oncological Department is strongly advisable.
**D73** A RANDOMIZED MULTICENTER TRIAL ON INFORMATION TOOLS FOR THE ITALIAN CANCER PATIENTS

U. Tirelli, F. De Lorenzo, E. Ballatori
On behalf of AIOM – AIMaC

**Background:** The importance of an effective communication for cancer patients is well-documented. Communication is one of the patients’ top priorities. A good communication decreases anxiety, drug usage and postsurgery complications. Since in Italy patients are becoming more and more involved in the decision-making process concerning their health, information tools are critical for the doctor-patient communication. Nonetheless, an old-fashioned cultural background has to be overcome as cancer still means poor prognosis and hence despair and anguish are overwhelming. Some doctors still believe that if the patient is fully aware of his/her disease, depression is taking over. Whether the doctor and the patient’s relatives rate him/her prepared to receive the information is a key factor. The study findings would be helpful to statistically determine what the Italian cancer patients want most.

**Method:** AIOM, the Italian Association of Medical Oncology, and AIMaC, the Italian Association for Cancer Patients, are carrying out a randomized, multicenter trial in order to evaluate how the patients rate the information received by the oncologists, how effective and useful AIMaC’s booklets and videotape are, and also how information on hard copy and video affects the patients psychologically. Twenty three centers from all over Italy have joined the study. Three hundred and thirty patients have been enrolled. Admittance criteria are as follows: malignant neoplasm (colon, breast, lung, prostate, cervix, ovary, stomach, liver, brain, Hodgkin’s and non-Hodgkin’s disease, melanoma), 18-80 years of age, first chemotherapy ever (to be administered for at least two cycles). Patients are required to fill in a set of questionnaires.

**Results:** As of April 2002, 10 centers have ended their accrual totalling 152 patients, while the remaining 13 centers are expected to return the case record forms soon. Data recording on EXCEL sheets has just begun.

**Conclusions:** This is the first Italian randomized study on how cancer patients perceive the usefulness of the new information tools. Also the effect of the three different ways of getting information on diagnosis and treatment on the patients’ psychological distress has been evaluated. The final results on the whole study group are going to be reported at the Turin AIOM Congress.

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**D74** INFORMATION AND COMMUNICATION OF AN ONCOLOGICAL DIAGNOSIS: COMMUNICATION EFFECTIVENESS EVALUATION AND NEEDS ANALYSIS

Dept. of Medical Oncology, University of Verona

**Introduction:** today the oncologic patients wants to take an active part in the choice of the possible treatments, infact it has been observed a major trend to tellcommunicate the truth to the oncologic patients. The communication is the central moment between the patient-doctor relationship and the technical need to inform the patient: the communication is the humanized information. Several studies have analyzed the information but few analyze the communication and the awareness degree of the disease.

**Patients and methods:** we composed a questionnaire which is made up of two specular parts, one for the doctor an the other for the patient. We evaluated the doctor ability to communicate about the diagnosis, therapy and prognosis through the confront with the patients’ understanding about diagnosis, therapy and prognosis. We also analized the patients’ emotions and needs. Since March ’00 to October ’00 we evaluated 137 pts (53 males and 84 females) aged from 30 to 60 years and a school education mean-high. The most frequent tumors were the breast, colon-rectus, lung and kidney cancer; good prognosis 70% and poor 30%.

**Results:** doctor communicates completely the diagnosis (95%) and the prognosis (85%) when the prognosis is expected to be good, but these percentages decreased to 76% and 12% respectively when the prognosis is poor. 128 pts (94%) believe to have understand the diagnosis but, only 88 (64%) are able to define their disease. 128 pts (94%) want to be informed about the disease, 108 (79%) about the prognosis, and 104 (77%) even if is expected to be poor. Doctors communicate correctly about therapy and adverse effects, infact the accordance between the doctors and patients answers is 77% (expecially for CT and RT, not for ormonotherapy). The most important patient’ emotions were: hope (47%), fear (27%) and anxiety (10%), but these are not perceived by doctors. The expressed needs were about communication.

**Conclusion:** The diagnosis and prognosis communication makes depend to disease’s stadium and prognosis. The most of patients want to be informed. The communication about therapy ad adverse effects is good except for ormonotherapy. Pts prefere a doctor able to dialogue and to perceive theirs needs and emotions.