Objective: To explore the long-term effect of cancer diagnosis and treatment on physical, emotional and social well-being in patients diagnosed with breast cancer 10 years ago.

Methods: We used the population-based Eindhoven Cancer Registry to select all women diagnosed with breast cancer in 1993 in eight community hospitals in the southern part of the Netherlands. Specialists mailed (or will mail) questionnaires to 362 breast cancer survivors. The Illness Intrusiviness Ratings Scale (Devins, 1994) was used to assess the impact of disease.

Results: At the time of abstract preparation we received 75 questionnaires from 97 patients of three hospitals (response rate 77%). This abstract therefore describes preliminary results: Final results will be presented at the EBCC. Ten years after breast cancer diagnosis, 57 (76%) of the women were still under specialist surveillance. As a consequence of the diagnosis and treatment of breast cancer, 43 women (57%) reported to have specific complaints: 30 (40%) reported arm problems (swollen, painfull arm) because of axillary lymph node dissection, 12 (16%) women reported fatigue. Negative consequences of cancer on *current* psychological wellbeing was reported by 13 women (17%), whereas 37 women (49%) reported positive effects. Work was negatively affected in 12 (16%) women, but positively in 21 (28%). The relationship with their partner was positively influenced in 29 women (39%), whereas 6 women (8%) reported a negative impact. Twenty-two (29%) women had less confidence in their body.

Conclusions: Ten years after breast cancer diagnosis, more than half of all women still have complaints related to diagnosis or treatment. A painfull arm is the most commonly reported physical problem. Although many women also report a positive influence on psychological and social wellbeing, still a small proportion (1 out of 6) have psychosocial problems as a consequence of their cancer. As the number of cancer survivors is growing, it is important to address these issues.

199 POSTER

The multidisciplinary team at the breast clinic – the patient perspective

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The diagnostic breast clinic provides the clinical set-up for investigation of breast lesions. High risk women are offered periodic breast examination and special counseling as requested. The multidisciplinary team includes doctors (surgeons, oncologists, breast radiologists), specialist breast care nurse, social worker and secretary. During 2002, 8900 breast examinations were performed and 247 new cancer patients were diagnosed.

We conducted a pilot study to evaluate the patient perception of the team members. Women were asked to fill a questionnaire which scored on a 1–3 scale their satisfaction of team members by accessibility, information provided, professionalism of intervention, emotional support and empathic attitude. An overall satisfaction score was calculated for each patient. 102 women filled in the questionnaire. 57 of them new breast cancer patients and 45 healthy women who came in for regular check ups.

The results of the two groups were compared (score 1 for high – 3 for low).

Breast cancer patiens satisfaction score level was: Doctor 1, 82.6%; 2, 16.4%; 3, 1%. Nurse 1, **93.75%**; 2, 6.25%; 3, 0%. Social worker 1, 77.5%; 2, 18.5% ; 3, 4%. Secretary 1, 76%; 2, 23%; 3, 1%.

Healthy women satisfaction score level was: Doctor 1, **86.64%**; 2, 12.36%; 3, 1%. Nurse 1, 71.65%; 2, 28.35%; 3, 0%. Social worker, not applicable. Secretary 1, 69.1%; 2, 28.09%; 3, 2.81%.

We concluded that for the newly diagnosed breast cancer patients the role of the specialist breast care nurse in the multidisciplinary team – **is most dominant** and more significant than for the healthy women visiting the clinic. The results demonstrate that those are the patients who need the most professional nursing intervention including information and emotional support during the diagnostic process.

200 POSTER

Locus of control, psychological adjustment and disease outcome in breast cancer patients

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The CLCS (Cancer Locus of Control Scale) was developed by a Dutch team in order to study the specific beliefs of control in cancer patients (Pruyn et al., 1988). This tool was validated in an English population of 68 subjects suffering from various cancers (Watson et al., 1990).

The present study had two main objectives: first, to test the construct and concurrent validity of the French version of the Cancer Locus of Control Scale by establishing its factor structure and its relationship with certain dispositional and transactional variables and secondly to test the predictive validity of the French version of the CLCS by establishing its relationship with adaptive issues measured two years after. This French version was administered to 157 women suffering from a first breast cancer: 75 patients treated with induction chemotherapy and 82 by surgical excision at the Institut Bergonié in Bordeaux (including 25 mastectomies and 57 tumorectomies). The Body Image Questionnaire was used as the measure of body image, the State Trait Anxiety Inventory measured state and trait anxiety, the Perceived Stress Scale measured perceived stress, the Social Support Questionnaire measured perceived social support and the Ways of Coping Checklist measured three dimensions of coping. A factorial analysis of the CLCS confirmed the three factors founded by Watson: internal causal attribution, control over the course of the illness and religious control. Correlations with the others measures indicated that internal causal attribution was associated with high state and trait anxiety, unfavourable body image, emotion-focused coping and problem-focused coping.

Control over the course of the cancer was positively associated with problem-focused coping and emotion-focused coping. Religious control was negatively associated with perceived stress. Evolution of the disease, emotional adjustment and quality of life were assessed in 75 on the 157 breast cancer patients two years after diagnosis and evaluation of cancer locus of control. Hierarchical regression analyses indicated that internal causal attribution predict further state anxiety. No association was founded between locus of control dimensions and evolution of the breast cancer.

201 POSTER

Psychological and physical symptoms in the final phase of breast cancer

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Breast cancer is one of the most frequent causes of death for women in developed countries. Incidence in Spain range between 40 and 55/100.000 inhabitants and in female population is the 20% of total dying by cancer. It is necessary to cover and pay attention to the final stage of this disease in the physical and biopsycosocial aspect, giving all the patients an integral care. In this study we present the most frequent symptoms and their control in a group of patients death by this disease.

Material and Methods: In Sanitary Area 11 in Madrid, there is a co-ordinated palliative program of care to terminal oncologic patients. Since November 1992, 2114 patients have been attended until death at home. 218 were diagnosed of breast cancer and they are the target of the study. All of them had received at least two visits in order to evaluate the response.

Results: Median age was 65.6 years old (28–94). Distribution of the patients: Women: 217, men: 1. All had proved hystologic diagnosis, and metastatic locations were: osseous 52%, hepatic 34%, lung 36%, NSC 17%, ganglionary 16% and others 18%. Median survival of breast cancer patients were 93 days instead 52 days of the rest of the patients included in the palliative program. Median number of symptoms in 1st visit were 7.6, in 2nd visit were 4 and in the last one visit were 3.7. In physical sphere the more frequent symptoms were dry mouth 79%, pain 77%, anorexia 71%, asthenia 67%, constipation 61%. In the psychological sphere the sume of sadness, distress, anxiety and depression reach the 60% of frequency in appearing.

The pain symptom is specifically analysed in function of the intensity perceived by the patient (VAS) and in function of its origin (visceral, osseous, and neuropathic). Initial medium VAS is 7.5 and at the final is 3.6. The type of pain with higher initial VAS are visceral 6.4 and neuropathic with 7.1. In order to control the pain, drugs recommended by OMS in its analgesic scale are used with a sequential method in the analgesia. Media of the visits/affected patient of breast cancer is 13 instead of 9 of the total. 297 visits to psychologists have been done.

Conclusions:

Final phase of breast cancer patients is long and with a wide range of symptoms.

Impact on physical and psychological sphere need to be evaluated and treated.

It is necessary to do active and continued palliative care to improve, as possible, their quality of life.