a sense of loss of control, there are a multitude of relationships involved which may help or cause distress to the person dealing with cancer, the health care team while often supportive sometimes failed to see the needs of those they cared for, while people with cancer value the expertise and knowledge of the health care team they also want the team to demonstrate compassion and sensitivity while delivering care and information, while a few people had found particular meaning to aspects of their experience all recognised that the ongoing process of searching to find meaning continues after treatment finishes. It is hoped that by listening to the experiences of these individual people living with cancer the insights gained will support the health care team in their efforts to help those undergoing treatment for cancer.

Frankl, V.E. (1959) Man's Search for Meaning. London. Hodder & Stoughton

1508 INVITED

The sense or nonsense of isolation

P. Crombez. *Institut J. Bordet, Onco-Hematology Department, Brussels, Belgium*

Infectious complications are a major cause of morbidity and mortality after haematopoietic stem cell transplantation (HSCT). Protective isolation (PI), especially in laminar airflow (LAF)- and/or high-efficiency particulate air (HEPA)- rooms remains still a controversial issue.

Numerous studies have assessed the effect of these measures with conflicting data. Most are descriptive, with only 9 prospective randomised studies, or tested several prophylactic interventions simultaneously making it difficult to determine the impact of PI alone.

The established guidelines concerning isolation practices are based on opinions of respected authorities or expert committees without evidence on the usefulness of PI. Only some airborne infections like nosocomial Aspergillosis can effectively be prevented by the use of LAF or HEPA filtration. But what about the preventive effect of these measures against endogenous bacterial or viral outbreaks? These cannot be prevented by strict isolation and led together with other factors; like financial costs, psychological burden, and the change in supportive care, newer concepts of HSCT and a remarkable change in the epidemiology of infections; to the reconsideration of isolation practices.

In addition, several reports, although non-randomised, describes the feasibility of outpatient care after high-dose therapy and HSCT. The pooled statistics suggest that protective environments provided no benefit in decreasing mortality for the transplant patient.

Furthermore the risk of opportunistic infections is not limited to the period of neutropenia but continues during the whole phase of immunodepression until about 1 year after HSCT and while the patient is not hospitalised.

Despite lack of sufficient evidence regarding the sense of PI it could be recommended for inpatient care of high risk allograft patients, especially if there is a history of high incidence of Aspergillosis or if there are frequently (re) construction activities in the hospital. It is of great importance to incorporate in the hospital an infection control program with ongoing assessments to identify risks for the acquisition and transmission of nosocomial infections.

For other patients there is less or no sense of PI but several isolation measures remain primordial to be respected like strict hand disinfection.

Only the results of a prospective, randomised study of sufficient power will enable definitive conclusions to be drawn regarding the sense or nonsense of PI.

Special Lecture

1509 INVITED

Centering care: patient's perspective

S. Rozman. *Europa Donna European Breast Cancer Coalition, ED Slovenia, Ljubljana, Slovenia*

In the lecture we want to highlight the patient as an important role in the organization and planning of care. Nowadays more and more diseases become increasingly chronic and we are faced with different problems: issues of patient compliance to treatment, of patient participation in decision making, of patient being a member of the multidisciplinary team, the doctor-patient relationship, as well as the patient advocacy movement, are becoming increasingly the center of our attention. On the other hand, there is striving for professional excellence in health care management, and systems of quality assessment demand feed-back from the customers, in this case the patients. Patients find themselves also in the increasingly powerful role of consumers and there are consumer rights that need to be taken into account, warranted by customer protection charters. Most countries have endorsed patient's rights, too, but how to implement them is something yet to be discovered.

We no longer take it for granted that what the caretakers think is best for the patient is the best that can be done. We ought to know what the patients really want. A research has shown that patients want three main things: competent care, person-centered care, organized around patient's needs and holistic care that extends beyond basic clinical care to address wider patient needs and wishes. Within these themes are ten things that patients want: practical support-knowing how their everyday lives will be affected, and how they can cope; emotional support, provided in a systematic fashion; being treated as people, not as patients, numbers, or diagnoses; involvement in decision making, services as close to home as possible, provided that clinical quality is not compromised; less waiting for diagnosis, during treatment procedures, and in outpatients; follow-up to be as well planned and patient centered as the initial treatment; but they also want easier access to complementary therapies as a supplement to conventional therapies; skilful staff and specialist nurse support; as well as appropriate "hotel services".

Patients are often the last to be consulted when services are being designed, assuming that they are unable to cope with that role while in the middle of their struggle for recovery. When searching for a competent partner, one should take into account the long term survivors who are well informed, organized, able and ready to act as patient advocates in the planning activities.

Joint EONS/AFIC symposium
Evidence based management of adverse events

1510 Abstract not received

1511 INVITED

Hand–foot syndrome – evidence based management

C. Courtiol. *Cadre de Santé, Centre Alexis Vautrin, Nancy, France*

The hand–foot syndrome was described for the first time in 1974 in relation to a treatment with Mitotane. After Burgdorf (1982), observed the hand–foot syndrome during a high dose chemotherapy for acute myeloid leukemia, several cases followed and were named differently, like acroerythema, hand–foot syndrome, palmar plantar erythrodysesthesia syndrome, Burgdorf reaction, palmar plantar toxic erythema. It is a painful erythema located on the palmar and soles. In 1984, 5 fluorouracil (5FU) was reported as implicated agent : from 400 patients, 18 presented this syndrome, and 17 of them were treated with 5 FU; later other chemotherapeutic agents were related to this syndrome just like Caelyx.

In my presentation I will address various questions such as how many patients suffer from this syndrome ? How to prevent it? What advice should be given to the patient? What is the implication for nurses?

1512 INVITED

Skin problems – evidence based management

L. Lemmens, H. Marsé, E. Van Cutsem. *University Hospital Leuven, Digestive Oncology Unit, Leuven, Belgium*

New therapies targeting the epidermal growth factor receptor (EGFR) are active in the treatment of several types of cancer. Amongst the agents targeting the EGFR are monoclonal antibodies (e.g. cetuximab, panitimumab) against the extracellular ligand-binding domain of the receptor and small molecules (e.g. gefitinib, erlotinib) that inhibit activation of the receptor tyrosine kinase. Targeted therapies have a specific mode of action and as they are focused they usually affect fewer normal cells than cytotoxic drugs do. This gives a better side effect profile than that of cytotoxic drugs. However, EGFR-inhibitors often cause signs of skin toxicity, most often acneiform eruption. After an acute phase of acneiform eruption, patients can gradually develop dry skin, sometimes resembling atopic eczema. After several months of treatment, in 10–15% of the patients, nail changes can be seen: paronychia can be painful and mimics an ingrown nail. There are also some other minor effects, such as the growth of long curly and rigid eyelashes, teleangiectasia and hyperpigmentation, all usually appearing after several months of treatment. Several retrospective analyses suggest a correlation between the severity of rash and the activity of the EGFR-inhibitor. Prospective studies are ongoing to better understand these findings. Dermatologic side effects of EGFR-inhibitors should be taken seriously since they can cause physical and cosmetic discomfort, that may compromise compliance to therapy if left untreated. Although the number of large trials on the treatment of skin toxicity is limited, the experience is growing on the best management