– complexities of decision-making in cancer patients
– ethical difficulties: what is right, what is wrong?

This presentation will consider the findings in the context of current cancer care provision across the world and put forward suggestions and considerations for practice.

8013 ORAL

Disclosing/Informing the diagnosis of cancer to Turkish People and their close relatives: An Opinion Survey

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The aim of the survey was to find out the opinion of the Turkish people about cancer and in case their close relatives were affected by the disease, what their attitude and reaction would be like for disclosing the diagnosis of cancer.

This survey study was conducted at nine hospitals (7 university, military and state hospitals) 7 different cities with the help of 27 colloborators. Data were collected via using questionnaire which includes demographics (age, gender, proffesion, education level, whether they have or had had a cancer-patient relative(s) if yes, whether they had disclosed the illness to them or not and WHEN during the period of the illness; whether the affected relative was still alive) and questions on their personal opinion about cancer:

1. If they would request that their patient be informed of their disease after the diagnosis.
2. Whether or not they would stand to be informed if they had the disease.
3. If their answer to the previous question is yes, WHEN would they prefer to be told.
4. If they don't want to disclose the bad news of the cancer to their relative but condition warrants them to do so what would their reaction be like.
5. Why they would feel unwilling to disclose the bad news to their relatives.

A total of 6566 people from different residential centers all over Turkey took part in the survey. The average age of the participants were 33 (18–100) with men and women percentage of 53.5 and 46.7 respectively. The result showed that 57.7% of the participants don't want their relatives to be informed of the cancer diagnosis. The survey also showed that 54.8% of the participants' relatives had frequent occurrence of cancer. Those whose relatives were diagnosed of cancer was ($N = 3597$) 69.9%; those who told their relatives of their cancer disease after the diagnosis were ($N = 2516$); 71.5% said they disclosed the bad news to their close ones immediately after they had been diagnosed; 16.9% said it after months and 9% said it at a time the patients were close to their death. Of them 62.8% responded said their relatives had died from cancer. It was also seen that when the participants in the survey were asked about cancer and its treatment approach, the optimistic ones and the pessimistic ones who don't believe medical medication ratio, was seen to be 76.5% and 16.3% respectively; only 2.9% of the participants in the survey were totally hopefull and at the same time hopeless. According to logistic regression analysis, it is interesting to note that the youth, the aged, the female sex group, the less educated, those who don't want to say they had relatives who had cancer, or those who proclaimed it late and those whose relatives had died of cancer and don't believe in cancer medication; all said at first they wouldn't want their relatives suffering from cancer to be told at all.

8014 ORAL

Truth telling to cancer patients

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Breaking bad news to patients is a common occurrence in the hematology-oncology department. Yet, many healthcare providers tend to avoid these intimidated situations.

Purpose: To explore attitudes of physicians and nurses from the hematology-oncology departments and the general wards and cancer patients toward truth telling. To determine who should inform cancer patients of their diagnosis, optional treatments, side effects and prognosis. To examine differences between healthcare providers concerning truth telling.

Sample: 69 healthcare providers (23% physicians and 77% nurses) from hemato-oncology units and general departments and 35 cancer patients completed questionnaires dealing with attitudes and wishes regarding information given.

Results: 97% of the healthcare providers answered that if they had cancer they wished to receive more information regarding the diagnosis, prognosis and treatment comparing to cancer patients. Younger patients were more likely to share information regarding their illness with their relatives. The hematology-oncology staff had significant higher intention ($p < 0.05$) to share information with relatives than the general department staff. A nurse was found to be the most suitable caregiver to provide information regarding treatment side-effects ($p < 0.05$). Cancer patients would like to know less about their prognosis than healthcare providers. 80% of caregivers agreed to accept the patient's attitude not to be informed about their prognosis and 61% agreed that the healthcare provider can hide information if it can lead to desperation, depression or suicide attempt.

Conclusion: Training and education regarding this issue should be an ongoing process for healthcare providers which must adjust their attitudes and tailor intervention according to patients needs. This training should include clinical discussions, case studies and simulation exercises in order to improve the staff skills.

8015 ORAL

Stepwise implementation of an evidence-based specialist breast care nurse model in a Belgian breast cancer clinic: Impact on patient's satisfaction, a prospective study

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Background: To prospectively evaluate patient's satisfaction with primary operable breast cancer (POBC) prior to and following a stepwise implementation of an evidence-based SBN-model in a Belgian breast cancer clinic treating about 400 new patients with operable breast cancer (POBC) a year.

Methods. Patient's satisfaction was measured using a (validated) questionnaire (measuring 20 items) developed by the Belgian Dutch Clinical Pathway Network (BDCPN). Three groups of 60 consecutive POBC patients filled in the questionnaire: a first group prior to implementation, a second group after introducing a clinical path (from 1/1/2003 onwards) with scheduled consultations with a breast cancer specialist in the post-operative and follow-up phases of treatment, a third group after introducing a breast cancer nurse (from 1/2005 onwards) following patients systematically only postoperatively in the same setting and a fourth group having (from 1/2006) additional consultations of the breast nurse in the diagnostic and preoperative phase

Results. Introducing of a clinical pathway significantly improved patients satisfaction (group 1 versus group 2) regarding uniformity of information given on the disease and treatment ($p < 0.05$), reduced the waiting times during the stay in the hospital ($p < 0.01$), and beneficially influenced the information given upon discharge from hospital ($p < 0.01$). The amount of dissatisfaction higher then 10% among patients was reduced from 11/20 to 9/20 of the questioned items. Further introduction of the breast nurse in respectively the postoperative phase (group 3) en pre- and postoperative phase (group 4) further optimized the way patients appreciated the information given to them about the disease, investigations and treatment ($p < 0. 05$), the appreciation of the kindness of the treating personnel ($p < 0.05$). The level of dissatisfaction was further reduced having only 7/20 items in group 3 and only 1/20 items in group 4 ($p < 0.05$ versus group 1, 2 and 3) scoring higher then 10%.

Conclusion. Patient's satisfaction gradually improved following introduction of evidence based clinical pathway and breast cancer nurse model in our breast clinic. Particularly the role of breast nurse seems to be of major importance to guide patients through the pre- and postoperative phase of their treatment

8016 ORAL

A nurse led out-patient oral chemotherapy service for the delivery of capecitabine tp patients with colorectal cancer in North East Scotland: an audit of the first 3 years

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Background: A nurse led out-patient chemotherapy service for capecitabine monotherapy for adjuvant or palliative treatment for colorectal cancer (CRC) was started by the Anchor Unit, Aberdeen, in September 2003. The Unit serves a large geopgraphical area of North East Scotland including the remote Orkney & Shetland Islands. The aim was to improve the service for patients, particularly those living in remote areas and to reduce pressure on the hospital service, and intravenous chemotherapy service in particular.

Materials and Methods: An audit of the prospective database from September 2003 to November 2006. Data used included: patients diagnosis; performance status (PS); concurrent conditions; previous

treatment; blood results; scan results; reasons for stopping treatment and capecitabine therapy (starting dose, number of cycles completed, toxicities, dose adjustments and treatment delays).
Results: During the period 177 patients used the service (100 with metastatic disease, 77 adjuvant). 169 (95%) of patients received capecitabine at 75 or 100% of the recommended starting dose (ie 1250mg/m^2 bd), and 8 (5%) received lower doses due to either poor renal function or PS. 71% of patients completed their treatment without further dose adjustment, but adjustments and treatment delays were required in 28% and 59%, respectively, for patients with metastatic disease and 38% and 61%, respectively, for those receiving adjuvant therapy. Capecitabine was well tolerated; grade 3 toxicity accounted for <7% of adverse events recorded, and there were no grade 4 events. The results are comparable with those from the published randomised trials in both metastatic and adjuvant CRC submitted for capecitabine registration suggesting appropriate monitoring by the nursing staff.
Conclusions: Capecitabine chemotherapy can be supervised by trained nursing staff in a safe and effective manner to out-patients spread over a large geographical area, with considerable reductions in patient travel requirements and demands on central cancer centre resources. Every year the Anchor Unit has saved about 2000 bed days as well as avoiding the need to reconstitute around 2,800 litres of iv chemotherapy. Feedback from patients has been overwhelmingly positive and the clinic has now been adapted to cope with the switch to combination chemotherapy.
The audit has been supported by an educational grant from Roche Products Ltd.

8017 ORAL

Facial disfigurement – moving on in life

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A patient, who has undergone surgical treatment for head and neck cancer, often suffers from facial disfigurement, as a result of treatment. The disfigurement is associated with psychosocial problems, such as depression, social anxiety and isolation. Knowledge about the patient's re-socialisation process after having experienced facial disfigurement, what kind of support and caring is needed and how – or if – nurses meet these needs, are lacking. Knowledge that can be used as background in a later successful intervention.
This project uses the research method Grounded Theory. 15−20 patients are being included. The patients are contacted shortly after the surgical treatment, after six month and after one year. Each time a conversation between a nurse and the patient is audio recorded, followed by individual interviews with the nurse and the patient. The patients and the nurses are included, using theoretical sampling, data is analysed in a constant comparative process and coded, using the recommendations from Glaser. Preliminary results of data collected from patients shortly after the surgical treatment, show following:

- patients uses different strategies such as focusing on inner beauty instead of beauty in appearance, and such strategies as relaying on being able to express why they have a different look will make people they meet understand and accept
- nurses minimise the patients problems, getting used at looking at disfigurement and thereby adapting blindness to the effects of a different look
- nurses only talk about things they can act on, choosing practical problems in preference to psychosocial problems
- nurses use standardized care, having to deal with a big number of patients every day and a tendency to focus on problems related to specific areas instead of the patient as a complex individual.

Joint EONS/ISNCC/ONS symposium
(Mon, 24 Sep, 16:00−17:30)
Hereditary cancer risk assessment: what is missing?

8018 INVITED

Cancer risk assessment in gastrointestinal malignancy: a challenge?

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In 2007, an estimated 3 million people in Europe will be diagnosed with cancer, 1700000 will die of cancer. Estimates of the premature deaths that could have been avoided through screening vary from 3% to 35%, depending on a variety of assumptions. Beyond the potential for avoiding death, screening may reduce cancer morbidity. Screening means testing people for the early stages of a disease before they have any symptoms. Before screening for any type of cancer can be carried out, physicians must have an accurate test. At the moment, there is no screening test reliable enough to use for pancreatic or gastric cancer. For colorectal cancer(CRC), the second leading cause of cancer death, some tests such as fecal occult blood tests and flexible sigmoidoscopic examinations are the recommended screening tests. Beside screening, individuals known to be at high risk (personal history, strong family history and genetic mutations and polymorphisms) need also to be identified. However, after identification, adherence to CRC screening is poor, both in average as higher risk individuals, due to lack of knowledge of CRC risk and the screening recommandations. Also psychological factors, such as perceived risk of CRC have been cited as important factors with screening compliance. Nurses can play an important role in the development of screening programs and (genetic)counseling. Indeed, by improving knowledge and approriate risk comprehension of individuals and health care workers, it is possible to increase lifelong, long-term screening adherence and decrease the number of affected individuals.conclusion: the development of screening programs for CRC, and probably in the future for other gastrointestinal malignancies, is a challenge, in which nurses have a special task of counseling and promotion.

8019 INVITED

Psychosocial issues in screening for hereditary cancers: implications for practice

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Genetic mutations for both hereditary breast/ovarian cancer and hereditary colorectal cancer have been identified within the last 15 years. As a result, the psychosocial research within this topic area is continuing to emerge. To date, the psychosocial literature related to genetic testing for these cancers has focused primarily on the motivations and psychological impact for the individual during the trajectory of genetic testing (i.e., before, during, and after receiving the genetic test result). Recently, work is beginning to unfold regarding the impact on the family. The genetic test reveals not only information about the individual but also about the potential risks for relatives as these partciular mutations are inherited in an autosomal dominant fashion.
There are a range of psychosocial issues inherent in screening for hereditary cancer. For example, access to relevant information, perceptions of risk, elevated anxiety and emtional distress, and disclosure of genetic test results have been identified as concerns. Health care providers need to be aware of the psychsocoial issues and have the capacity to implement the approrpiate interventions. Health care providers may be challenged in taking approrpiate action because of (1) lack of knowledge regarding the psychosocial issues, (2) lack of skill in conducting the proper assessment, and (3) lack of awareness regarding appropriate interventions.
There is a critical need for more research in this area to build the body of evidence for practice. However, there is a growing understanding about what interventions could be useful. This presentation will highlight the current knowledge available for practice regarding psychosocial care of individuals undergoing screening for hereditary cancer.

8020 INVITED

Comprehensive cancer risk assessment and management: the essence of oncology nursing

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The genetic revolution has transformed to the genomic revolution with a broader scope and boundless implications. Cancer risk assessment and management, with or without genetic testing, has moved from specialty programmes to general oncology practices. This necessitates an increased role for oncology nurses, which is a wonderful opportunity for professional growth. The oncology nurse must be fluent in cancer biology and basic genetics to manage rapidly evolving care responsibilities of personalized medicine. Presented here is an in-depth case study of one cancer survivor who undergoes genetic testing by her oncologist. Oncology nurses are a crucial part of the team that assists patients by proper identification of families with increased cancer risk, appropriate referral to genetic counseling, accurate prevention and screening education, and adjustment and follow-up support after the diagnosis of hereditary predisposition.