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.
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8017 ORAL

Facial disfigurement – moving on in life

H. Konradsen. *University hospital of Gentofte, Hellerup, Denmark*

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?

L. Lemmens. *University Hospital Leuven, Digestive oncology, Leuven, Belgium*

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

M. Fitch. *Toronto Sunnybrook Regional Cancer Centre, oncology nursing & supportive care, Toronto, Canada*

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

A. Strauss Tranin. *Cancer Genetic Consultants LLC, Credentialed in familial cancer risk assessment and management, Leawood, USA*

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.