

Delegates agreed a consensus on research, genetic predisposition, psycho-social status, treatment and notably quality of care. "The Florence Statement" demanded that all women have access to multidisciplinary breast clinics based on populations of around 250,000; also it called for mandatory quality assurance programmes for breast services. With the intention of assuring a high quality specialist service Europe-wide, a working party was established to consider what should comprise a specialist service. These resulted in the publication of the "Requirements of a Specialist Breast Unit", which represents the opinion of the European Society of Mastology (EUSOMA) and EORTC on the standards required for forming high quality Breast Unit across Europe. These Guidelines have been generally well received and have been influential in the introduction of the multidisciplinary working in several Countries. "The Brussels Statement" following EBCC2 drew attention to these guidelines and demanded that processes of accreditation of breast units be implemented. The importance of the establishment of multidisciplinary breast units was again stressed in "The Hamburg Statement", which followed EBCC4. Attention was drawn to the approval given to this in the European Parliament (2004).

Meet the Manager (Wed, 26 Sep, 13:45–15:45) Implementing new technology in health care

8076

INVITED

Innovations in technology and impact on healthcare

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Rapidly evolving technologies such as computer information systems and molecular biology are critical for cancer care. Health information technology considered to be key to improving efficiency and quality of health care. Health information technology has been shown to improve quality by increasing adherence to guidelines, enhancing disease surveillance, and decreasing medication errors.

Information technology is becoming increasingly important, as a communication medium and a means of involving patients in their care. Information technology also being used to improve patient care. The use of handheld computers has been studied to assess and manage symptoms for patients receiving chemotherapy by Kearney et al (2006). The patients in this project used handheld computers to monitor and assess chemotherapy-related side effects, send this information to the cancer centre and to automatically provide them with tailored information on effective and appropriate self-care strategies. Patients believed the handheld computer had improved their symptom management and felt comfortable in using it. The health professionals also found the handheld computer to be helpful in assessing and managing patients' symptoms. This project suggests that a handheld-computer based symptom management tool is feasible and acceptable to both patients and health professionals in complementing the care of patients receiving chemotherapy.

Electronic patient records and telemedicine have enormous potential for communication and networking across geographical boundaries. Advances in computer and telecommunications technologies are allowing nurses to transport nursing care to patients in alternate care sites and remote geographic areas. Telehealth technology broadly encompasses computers, the internet, televisions, voice and video systems, and distance-learning devices, when coupled with communication lines, enable patient care, education, and/or provider contact to occur over long distances. As the application of information technology to the healthcare industry becomes increasingly important, the actual storage and dissemination of health information in electronic form raises concerns about patient privacy and data security. These concerns have increased as more sensitive material is stored in medical records, such as HIV status, psychiatric records, and genetic information.

The delivery of cancer care will continue to be affected by developments in the field of healthcare informatics and rapid changes in information technology. The use of technology, such as that covered in this discussion, has obvious implications in relation to patients receiving treatment for cancer in helping them to understand the effects of their cancer and treatment whilst supporting them to achieve a balance between seeking professional care and developing their own self-care abilities.

Aim: To explore and discuss innovations in technology and how it is impacting on health care. Main topics are:

- i. Scope of new technology in health care
- ii. Interface between industry and health development
- iii. Evidence for benefits
- iv. Implementation into practice
- v. Evaluation and management costs

Podium session (Wed, 26 Sep, 16:00–17:30)

Managing new treatments and side effects in innovative approaches

8077

INVITED

Hand-foot Syndrome: Cause, Effect and Management. Nurse-led monitoring using new technologies

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Background: Hand-foot Syndrome (HFS) or palmar-plantar erythrodysesthesia is a common side effect of specific cytotoxic drugs with prolonged serum levels. HFS is rarely serious, not life-threatening but can be inconvenient, interfering with normal activity. The pathophysiology of HFS is unclear but early identification and vigilant monitoring by the patient and the nurse play a vital role in the prevention of worsening of symptoms.

Management: Dose interruption if possible and dose reduction of drugs rapidly lead to a reversal of symptoms. Conclusive evidence for topical and pharmacological treatments to alleviate pain and cutaneous integrity, is still lacking. More adequately powered randomised trials are required. As the goal of care for HFS is to prevent grades 3 and 4 toxicity, we have successfully used real time symptom monitoring of HFS utilising novel mobile phone technology linked to a server which communicates patients' symptoms to healthcare professionals. Chemotherapy side effects including HFS are registered and advice on symptom management is rapidly provided.

Content: The presentation will cover the nature of HFS in patients receiving chemotherapy, its recognition, severity and the nurse-led management of HFS including monitoring by mobile phone technology.

8078

INVITED

Bowel problems: The role of a nurse endoscopist in the diagnosis of bowel cancer in a surgical outpatient clinic

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Introduction: Since the introduction of the NICE GP Referral Guidelines for bowel cancer in 2002, and the 'Two Week' clinic, there has been an increasing demand for Nurse Endoscopist (NE) led clinics. The success of NE led clinics is dependent on the efficiency of the NE in detecting bowel cancer at these clinics, both on endoscopy and referral for total colonic imaging.

Method: All patients attending a surgical colorectal outpatient clinic in Portsmouth (2005 and 2006) were studied to determine the proportion of examinations carried out by the NE, compared with other clinicians, and to compare the effectiveness and efficiency of examination by the NE. All patients seen in the clinic had the outcome of their initial visit entered on to a proforma and recorded on to a database, and if they were referred for barium enema, colonoscopy or CT colonography. Results of investigations were recorded on to the database.

Result: 29% (1544/5391) of surgical colorectal outpatient clinics were carried out by the NE in 2005 and 2006. A mean age of 61, and gender distribution of 55% female was the same for both NE led clinics and 'other clinician' led clinics.

Flexible sigmoidoscopy was carried out in 96% (1484/1544) of NE clinics, and 90% (3458/3847) in 'other' clinics. In NE led clinics 42% (618/1484) of patients were referred for colonic imaging (BE, CT Pneumocolon, Colonoscopy) compared with 35% (1196/3458) by 'other clinicians'.

37% (1822/4942) of the surgical colorectal outpatient clinics were 'fast track' clinics. 43% (643/1484) of NE led clinics were 'fast track' referrals, compared with 34% (1179/3458) for 'other clinicians'. The NE saw 35% (643/1822) of all 'fast track' referrals. In 'fast track' clinics only, there was a diagnostic yield (DY) of 11% (69/643) of cancer for NE led clinics, compared with a DY of 9% (104/1179) for 'other clinicians'.

A median distance of 50 cm was reached by both NE and 'other clinician'. The NE detected a polyp on flexible sigmoidoscopy (FS) in 15% (223/1484) of patients, this compared with 11% (391/3458) detected by 'other clinicians'. A biopsy was taken of the polyp at FS in 54% (121/223) of examinations by the NE, and 51% (198/391) by 'other clinicians'. 36% (44/121) of biopsies taken at FS by the NE were found to be an adenomatous polyp on pathology, this compared with 58% (115/198) for 'other clinicians'.

One distal cancer was missed on FS by the NE. No distal cancers were missed by 'other clinicians'. Two proximal cancers were missed after initial examination by the NE. One was referred and received full colonic imaging but the cancer was missed during colonoscopy. And the other did not have 'high risk' symptoms for proximal cancer (IDA or abdominal mass) to indicate referral for proximal colon imaging. Five proximal cancers were