Methods: At the Family Cancer Clinic of our hospital the Dutch modified DT (a horizontal numeric scale ranging from zero (no distress) to ten (unbearable distress), and an adapted version of the problem list, was completed by 100 women at increased risk of developing BC due to a genetic/familial predisposition (mean age 45.5 years; range: 22 to 75). Additionally, the women randomly filled in either the Hospital Anxiety and Depression Scale (HADS) as psychological component ($n = 48$) or the somatic subscale of the Symptom Checklist-90 (SCL-90) as physical component ($n = 50$) to identify whether the DT-score is determined by mood and/or somatic complaints. Further, the women filled in an evaluation form.

Results: The median score on the DT was 2 (range: 0 to 9). Nineteen percent scored above the DT cut off score (i.e. had a score $\geqslant 5$). The mean score for anxiety (HADS) was 4.4 (sd = 2.8), for depression (HADS) 1.9 (sd = 2.6) and for the somatic subscale of the SCL-90 17.2 (sd = 5.3). Differences between women scoring below and above the cut off score for anxiety, depression and somatic complaints were significant. With regression analysis adjusted for age, the contribution of mood and somatic complaints, respectively, were investigated. The standardized regression coefficient for anxiety was 0.32 (ns), for depression 0.14 (ns) and for the somatic subscale 0.49 ($p < 0.001$). The explained variance for anxiety and depression was 16%, and for somatic complaints 24%. The differences between the standardized coefficients were not significant. By means of the problem list the DT scores were clarified and attributed to the increased risk of cancer (47%), concern about the result of the surveillance appointment (36%), sleep disturbances (31%), and fatigue (31%). The evaluation form was filled in by 73 women; the physician had discussed the DT in 50% of these women, which was appreciated by 80% of them. 62% Would recommend the use of the DT for other patients.

Conclusion: The use of the DT/problem list seems promising for the current population, and was appreciated by the majority of the women. Since mood and somatic complaints did not differ significantly in explaining the experienced distress, other candidate factors need to be examined.

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A study to identify which factors influences whether a patient chooses to enter a randomised clinical trial and to identify differences between patients' and their partners'/supporters'perception of these factors

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Much research has been done to look at factors that may increase patient recruitment to clinical trials and the barriers to their participation. These factors have been explored largely from the perspective of the patient and the doctor, little research has been done which involves partners/supporters. The aim of this study was to identify which factors influence whether a patient chooses to enter a randomised clinical trial and to identify differences between patients and their partners'/supporters' perception of these factors.

This study has measured the opinions, influences on and level of understanding of patients and their partners/supporters recently offered a clinical trial in a North London Cancer Center. A cross sectional survey approach was used. An existing questionnaire by Wright et al (2006) was used and modified for partners/supporters. Data were collected from 118 questionnaires completed by patients' and their partners'/supporter'. The main statistical tests used in the study were chi-squared test to determine which factors correlated with the patients decision to enter the trial. Paired t tests and chi-squared were used to compare differences between patients and their partners/supporters. Finally odds ratio analysis were performed on the significant factors found.

Analysis of the data has revealed that influences on patients included the importance of altruism as well as personal benefits and having sufficient time in which to make a decision on whether to participate in a clinical trial.This study has shown that the nurse helped the patient make the decision regarding trial entry rather than the doctor as previously found in the literature. This is the first study to try to explore the opinions, influences and understanding of partners/supporters in relation to recruitment to randomised clinical trials. This study has shown the characteristics of the partner/supporter who has been positively influential in the patients' decision to enter into a clinical trial are that they generally favour clinical trials and see the benefits that the trial might bring to the patient. They need sufficient information, especially around potential side effects and time to allow them to help the decision making of the patient but, at the same time, they realise that the decision is a difficult one for the patient to make.

Implications for practice are that patients and partners/supporters need to have enough information and time with the doctors and nurses and the benefits of the trial need to be clearly explained. Partners/supporters should be encouraged to attend all consultations and be supported through the whole trial process.

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Health status in breast cancer patients is influenced by trait anxiety and type of operation

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Aim: Since incidence rates of breast cancer are still increasing and mortality is still decreasing, more and more women are survivors of breast cancer. This makes research into health status and quality of life of these women increasingly important. The aim of this study was to examine the role of anxiety and type of operation in health status of breast cancer patients.

Method: The women that participated in this study, visited the department of Surgery of the St. Elisabeth, Maasland or Jeroen Bosch hospital, the Netherlands, because of breast complaints. At their first visit, before diagnosis, they completed an anxiety questionnaire (State-Trait Anxiety Inventory). One, 3, 6 and 12 months after their breast cancer operation, they completed the European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire Breast Cancer module (EORTC QLQ-BR23), a disease-specific health status measure. The EORTC QLQ-BR23 measures the following domains: Arm symptoms, Breast symptoms, Systemic therapy side effects, Upset by hair loss, Body Image, Sexual functioning, Sexual enjoyment and Future perspective. All patients could choose between breast conserving therapy (BCT) or a modified radical mastectomy (MRM).

Results: The ANOVA for repeated measures shows that there is a significant main effect of time in Body image ($p < 0.001$), Systemic therapy side effects ($p = 0.006$) and Breast symptoms ($p = 0.004$) 12 months after surgery.

There is a significant difference in Body image ($p = 0.012$), Future perspective ($p < 0.001$), Sexual functioning ($p = 0.013$) and Systemic therapy side effects ($p = 0.009$) between patients high on trait anxiety and patients not high on trait anxiety in the 12 months after surgery. In addition, a significant difference is found for Body image ($p = 0.007$) and Breast symptoms ($p = 0.000$) between patients who had a BCT and patients who had a MRM. Furthermore, there is an interaction-effect between time and trait anxiety for Body image ($p = 0.029$) and Future perspective ($p = 0.002$) and an interaction-effect between time and type of surgery for Breast symptoms ($p = 0.025$).

Conclusion: Breast cancer patients who score high on trait anxiety, experience significantly more problems with Body image, Future perspective, Sexual functioning and Systemic therapy side effects in the first year after breast cancer surgery than patients that do not score high on trait anxiety. Moreover, patients who underwent BCT had significantly more Breast problems than patients that had a MRM.

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The inner representation of illness and its influence on the decision making in breast cancer patients

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Background: The decision making is very important part of the treatment and disease experience in breast cancer patients. The decision making process is supposed to be equal in different individuals. However the individual personal features and actual possibilities of the brain functioning (including geriatric specific) influence a lot on the inner representation of illness. The inner representation of the illness has four levels: sensual, emotional, cognitive and motivational. The predominance of one of the levels is the result of the individual's psychological type of the character. The decision making regarding treatment process is based on the inner representation of the illness and needs different medical professional approaches in patients with different types of the character.

Patients and Methods: In the group of 100 breast cancer patients oncologist discussed the suggested methods of treatments: the description of the method, prognosis, side effects, quality of the life and social adaptation during and after treatment. All the patients were examined regarding their individual psychological type (MMPI, psycho-semantic test). 4 blocks of the sources were used in order to help patient to imagine the method and it's expectable result: visual, verbal, verbal-logic presentations and dialog with the doctor with patient's self activities (drawings and questions, comments). The effectiveness of each method was estimated with the help of psychologist.

Results: The 65% of the patients, who had the experience of the medical decision making before, told about the feeling of the more well-based and responsible decision with the help of the suggested sources The quantity of the time paid to different methods, questions regarding different ways of presentation and effective feedback after the different presentations and discussions positively correlates with the individual effectiveness of each method. 80% of the patients with the hysteric type of the character prefer the visual presentation, asthenic type of character prefer verbal logic with a lot of details (cognitive level of the inner representation of the illness) in 100% of the cases, hyperthimic type prefer active discussion (60%) and use a lot the motivational level of the inner representation of the illness.

Conclusions: The psychological diagnostics and suitable for each psychological type source for the representation and discussion of the medical information make the decision making process more effective in breast cancer patients.

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Improving QOL in breast cancer patients in resource poor developing nations: supportive care efforts by an Non-Governmental Organisation [NGO]

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Issues: Social stigma, fatigue, sexual dysfunction, sleeplessness, depression, pain commonly seen in Breast-cancer-sufferers. Palliative inaccessible in rural/tribal areas. Hence our NGO nurses took initiatives to help alleviate suffering of women with Breast cancer since October 2005.

Objective: Around 53 women die each year from breast cancer. Of these statistically over 90% express sexual-dysfunction, 68% experience unbearable-pain; 70% suffer social neglect/humiliation; 54% sleeplessness, nausea/vomiting; 37% complain fatigue and 64% had depression. Importance of spirituality/religion in coping with terminal-illness is increasingly recognized Hence Our NGO-nurses followed-up poor rural women unable to afford Rx Or who are in need of palliative care. we involved community-leaders to make more women involved in our spiritual healing sessions.

Methods: We surveyed 55 women suffering from breast-cancer through QOL-questionnaires. After 14 weeks with psychosocial support. Counseling & palliative support with anti-depressants/pain-killers/nutrition QOL improved to statistically significant level. Need in cancer palliative care has been evaluated using the methodology suggested by Oncologists. Besides symptom assessment was performed on weekly basis. Traditional faith-healers involved for more psychological impact on patients community.

Results: opioids administered in 35%. Diazepam as adjuvant-drugs in 23% patients. Pethidine common analgesic in 56% women, tramadol in 22%. >30% of cases in advanced-stage. Our NGO assesed that 20 specialist palliative care beds required for our Rural/tribal population of 6,00,000. 53% women expressed that religious/community support/faith was most important factor that helped them to cope with breast-cancer. We observed significant correlations between higher scores of spirituality with absence of depression. Likewise higher scores of QOL correlated with lack of sexual dysfunction/pain. Our NGO-initiative suggests that over 70% patients will need well trained specialist for home-based-care unit.

Conclusions: Life-span/QOL of breast cancer-sufferers depends on social acceptance & appropriate-palliative/psychosocial care. NGO-personals should be trained in Palliative-care-services. These data is being used for palliative care advocacy. Spiritual well-being increases end-of-life despair in terminally-ill. Field of Spiritual/psycho-social/community support is fertile ground for further investigations.

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Improving quality of sexual life in breast cancer patients in developing countries: beyond positions and techniques!

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Sex and cancer are two words that do not seem to belong in the same sentence.Female sexual function, identity and relationship may be dramatically wounded, physically and emotionally, by changes and challenges woman has to face when breast cancer disrupts her life, maternity may become the core of a major identity crisis for the 25% who are diagnosed during the fertile age. Chemo and hormonal therapies induce premature menopause causing vaginal dryness. Breast surgery may affect physical attractiveness and reduce easiness with breast foreplay, although this is difficult to be openly admitted. In our sexually silent society, a sex talk is culturally labeled as shameful, the myth that older women with breast cancer are no longer interested in intimacy, and the presumption that issues of survival overshadow sexuality, provide barriers to open communications. Dispelling the myth that all older people should have a declining interest in sex may help patients feel less reticent about discussing sexual matters. The very privileged relationship that oncologist have with their patients should permit them to assist the patient with this aspect of health and recovery. Sexuality is, by dogma, satisfaction par excellence which certainly does not mean lying in the arms of scantily-clad women, mouths reddened by desire, and terminating in one prodigious orgasm it is largely a function of the breadth of activities in ones repertoire and the degree to which one is open to learn and explore. Methods include educating patients about the phases of sexual functioning and the impact of treatment, allowing explore their ability to respond to sexual stimulation by self-pleasuring exercises, teaching sensate focus exercises that structure noncoital foreplay, changes in coital positions suggestions on resuming sex comfortably and self-help strategies to overcome specific sexual problems like painful intercourse, loss of sexual desire may help alleviating suffering.

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Patient's satisfaction and adequacy of information after breast oncological surgery – results of three different procedures

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Background: Psychological trauma after breast oncological surgery is a major issue. Our goal was to evaluate overall patient's satisfaction and adequacy of information comparing three procedures: 1) classical conservative treatment (*cons group*); 2) mastectomy and immediate reconstruction with latissimus dorsi flap (*LD group*); 3) conservative treatment and reconstruction with mammaplasty techniques (*mammaplasty group*).

Material and Methods: Fifty-four questionnaires were answered and patients were distributed as follows: 26 – cons; 19 – LD; 9 – mammaplasty. Procedures were undertaken by the same surgical team (Level II Oncoplastic Training Unit – EJSO 33 (2007) S1-S23). Parameters studied included: self evaluation of final aesthetic result; recommendation of procedure to others; search for additional information and adequacy of preoperative education; choice of other options; postoperative pain; time to recover daily activities. Statistic analysis was performed using Qui-Square test (statistical significance – $p < 0.05$).

Results: Regarding all groups, 62.7% of patients found overall aesthetic result excellent (score 6 on a visual scale of 1 to 6) but there was a significant difference between the three (cons – 80.8%; LD – 41.2%, mammaplasty – 50.0%). Only one patient wouldn't repeat or recommend his procedure (LD group). Although not significant, more women in LD group sought for additional information (cons – 34.6%; LD – 50.0%; mammaplasty – 37.5%). Despite the fact that only 48% of all women agreed that they were given more than one surgical option (cons – 36.0%; LD – 61.1%; mammaplasty – 57.1%; p = ns), an adequate preoperative education was achieved since 88.9% of all women felt themselves useful in final decision. Pain in the first postoperative day was higher in LD group, although not significant (>5, on a scale of 1 to 10: cons – 12.5%; LD – 31.3%; mammaplasty – 14.3%); in the seventh day there were no differences. There was a trend to recover later normal activities in LD group (>15 days: cons – 44.0%, LD – 76.5%; mammaplasty – 37.5%; p = ns).

Conclusions: Overall patient's satisfaction was good, although the aesthetic result in the LD group was considered inferior. As expected, the postoperative period in the LD group was more painful. Adequate preoperative information, with the pros and cons of the described procedures, can lead to a more enlightened choice.

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Ensure communication between ill mothers of breast cancer and their children

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Introduction: During last years, because of the important advance of medical technology in western countries, early diagnostic of breast cancer has increased in young women, many of them mothers of school age children that, at the moment of the diagnostic, use the most part of their daily activity breeding and raising their children.

After perceiving the great concern and dificulty that is for these young mothers to communicate their illness to their children, we thought about creating a help instrument which makes easier the communication process between them and their children.

Objective: To create a helping instrument (tale) which makes easier communication between mothers with breast cancer diagnostic and their children.

Free distribution of this instrument in public hospitals of our country, in order to be delivered to the patients in a quick and easy way.

Methods: For building the tale, we pay special attention to drawings, which specifically explain the meaning of the text. These drawings show the experience of the illness process (hospital admission, mastectomy,