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.

154 Poster

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.

155 Poster

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.

156 Poster

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%; $p = \text{ns}$), 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%; $p = \text{ns}$).

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.

157 Poster

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,