distinctive entities. Further prognostic discrimination could be obtained by application of the International Prognostic Index to most of the clinico-pathologic entities defined by the REAL classification

998

Biology and treatment of primary gastric lymphoma

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Most primary low-grade gastric lymphoma (NHL) recapitulate the histopathologic features of mucosa-associated lymphoid tissue (MALT). Therefore they often are called MALT-lymphoma, although this type of NHL does also occur in several other extranodal organs. NHL of MALT type do transform to high-grade NHL, the latter showing both components in about 33%..

Primary gastric lymphoma is a localised disease compared to nodal NHL with 75% being in stage I and II_1 though high grades have a higher tendency for a wider spread and per continuitatem growth into neighbouring organs.

There is a small predominance for the male gender. Clinical symptoms are uncharacteristic. History in low grades is longer than in low grades.

Discussion on the right treatment is still going on, though in the last years authors seem to favour a conservative organ conserving approach, which is backed by preliminary data from a prospective study, which demonstrates no advantage for stomach resection.

A completely new approach in the treatment of gastric NHL was triggered by data showing that Helicobacter pylori (H.p.) is a stimulus for the growth of low grade NHL. In prospective studies complete remissions of lymphomas after eradication of H.p. have been published, though it is to early to evaluate duration of these CRs.

999

The management of non-Hodgkin's lymphomas ANNO 1997

A. Hagenbeek. *Department of Hematology and Bone Marrow Transplantation, The Dr. Daniel den Hoed Cancer Center/University Hospital Rotterdam, Rotterdam, The Netherlands*

An overview will be given on the possibilities and limitations in the current treatment of non-Hodgkin's Lymphomas (NHL) of both low and intermediate/high grade malignancy. Although 50–60% of patients presenting with limited stages of low grade malignant NHL can be cured with involved field radiotherapy, no significant advances have been made in the treatment of patients presenting with advanced disease. In other words, for this special category of patients it has appeared to be impossible to change the natural biology during the past 30 years. However, new perspectives in the treatment of these indolent NHL's will be discussed (interferon, purine analogs, stem cell transplantation).

For the intermediate/high grade malignant NHL's CHOP chemotherapy still remains the standard treatment. At present, prognostic factor tailored treatments are being evaluated in prospective randomized phase III clinical trials. An overview will be given on the current state of affairs, ranging from intensified conventional chemotherapy to marrow-ablative treatment in selected poor risk groups.

Finally, realistic options for the treatment of relapsing patients will be indicated for the various disease categories.

1000

Role of high-dose chemotherapy and autologous bone marrow transplantation in the treatment of lymphoma

T. Philip. *C.L.B. Lyon, France*

• The selection of bad prognosis groups is mandatory if BMT is considered in first CR. It is now widely accepted that candidates for prospective studies can be defined as patients less than 55 years old at diagnosis, with at least 2 extranodal localisations or a tumour of at least 10 cm at diagnosis, with a bad Karnofsky score (<70%) or with bone marrow or CNS disease at initial presentation. This group is reported to have an expected survival with conventional regimen of 55% at 3 years. Only prospective and ramdomised studies are acceptable in this field.

• There is no indication for ABMT in primary refractory patients except in prospective experimental studies.

• Partial responders to first-line induction therapy are chemo-sensitive high-risk patients. This is probably the best indication for BMT in NHL.

Pilot studies with ABMT were able to report 71% disease free survival at 90 months, all with proven active lymphomas at time of BMT. These preliminary results should be confirmed, but BMT can be strongly recommended in 1991 for these patients if a biopsy shows active lymphomas after 4 courses of a conventional induction regimen.

• Patients who previously reached CR1 on conventional therapy and then relapsed, and who are not responding to conventional rescue protocols are calls *resistant relapses*. BMT is probably the only chance of cure and can be highly recommended.

Patients who previously reached CR1 on conventional therapy and then relapsed and who are still responding to conventional rescue protocols are called *sensitive relapses*.

A randomised study had shown that BMT is mandatory in theses cases.

1001

The role of the palliative care specialist. Controversies and definitions

V. Ventafridda, A. Sbanotto. *WHO Collaborating Center on Cancer Control and Palliative Care, European Institute of Oncology, Milan, Italy*

More than 60% of cancer patients are incurable. Problems of communications, physical and emotional symptoms control, environment and ethical issues are important in the process of dying. Palliative care specialists, with a team of caregivers should offer to those patients a compassionate and a professional help in which the medical role is only 50% of the entire care.

The oncologist professional is mainly bound to the clinical approach and require in several instances an integration with a PC specialist. Such experts may work in a symptom control team or in a special in-out patient unit. A number of university chairs on PC in UK, in USA and in other countries are growing, facing the need of a new approach on the care of cancer and other incurable disease.

WHO recommendations, reports of prestigious medical journals are stressing such needs in view of the fact that hospital death, assisted suicide and euthanasia are presently highly debated.

1002

Helplessness reduction in a palliative care unit (PCU)

M. Die Trill. *Dept. of Oncology, Hospital General Universitario Gregorio Marañón, Madrid, Spain*

Introduction: Due to the nature and uncontrollability of the illness and treatment side-effects, cancer elicits different levels of helplessness in medical staff working in PCUs.

Purpose: 1. Identify situations that give rise to staff helplessness in PCUs. 2. Describe behavioral manifestations of staff helplessness. 3. Provide behavioral interventions to reduce staff helplessness. 4. Provide guidelines to prevent the development of staff helplessness in PCUs.

Method: Effective consultation to staff members of PCUs in the context of learned helplessness theory will be reviewed, emphasizing the integration of behavioral medicine principles in the training of medical staff. Participation of symposium attendees may be requested.

Conclusion: The PCU constitutes a setting in which death and lack of control over patient care and survival are experienced on a daily basis. Therefore, identifying and controlling helplessness reactions of medical staff members have important clinical implications and will improve patient care and staff wellbeing significantly.

1003

No abstract

1004

How should we assess alternative medicine?

John F. Smyth. *University of Edinburgh, Western General Hospital, Edinburgh, UK*

The term alternative medicine (AM) embraces a variety of therapies that can be sub-divided into two board groups – physical and psychological. Physical therapies include diet, vitamins, herbal remedies and homeopathy, immune stimulants and acupuncture. Psychological methods include meditation, hypnotherapy, relaxation therapy and visualisation. Assessment of the value of AT alone or as a complement to conventional treatment (CT) is complicated. Furthermore the majority of patients using AM use several methods at the same time. Conventional methods of assessing medical

treatment should seek to avoid doctor and patient bias and both may be compromised when assessing AM! Physical methods of AM can be assessed by prospective randomised controlled trials, ideally testing one method versus placebo but given the self-selecting patient population more realistically comparing one method of AM with another. Psychological methods are best assessed by established quality of life instruments but careful study design is essential to try and control addition (non-declared) supportive therapies, and of course the effect of concomitant CT may adversely affect quality of life but increase survival. Patients motivation for using AM is usually a hope that survival will be increased and therefore the ultimate end-points in assessing AM should include quality of life studies and overall effects on survival.

1005

The role of the nurse in palliative care

S.C.C.M. Teunissen[1], Daniel den Hoed[2]. [1]*Centre for Development of Palliative Care, the Rotterdam Cancer Institute;* [2]*Clinic/University Hospital Rotterdam, Holland*

The role of the nurse in health care can be described based on their professional domain: the consequences of disease and treatment. It doesn't give us a very specific description of tasks, qualifications and responsibilities, but it is directive to come up to the different requirements for nurses.

Patients in palliative care are confronted very much with the consequences of disease and treatment, so is their family and the professional supportteam.

The role of the nurse in palliative care is not easy to describe because of the variety in organisational models dealing with palliative care problems. Nevertheless, there are similarities in the different settings in all our countries. In this presentation the similarities will be discussed in order to come to a common understanding.

The roles that will be discussed are:

(a) the nurse as the analyst of (nursing) problems
(b) the nurse as the co-ordinator of hostilic care
(c) the nurse as the advocate of the patient and the family
(d) the nurse as the teacher for patient, family and the health care professionals
(e) the nurse as the team-leader of the palliative support team.

Specific attention will be paid on the necessary use of measuring-instruments, communication skills and ways and means to obtain expert knowledge.

Central themes guiding the discussion about the nurses role in the interdisciplinary support team in palliative care are the 5 C's of:

(a) Co-ordination
(b) Communication
(c) Complementation
(d) Creativity
(e) Continuity.

1006

How far should we go in treating cancer patients?

J. Klastersky. *Department of Internal Medicine, Institut Jules Bordet, Brussels, Belgium*

At least 50% of the patients with cancer will not be cured by our current therapeutic efforts. It does not mean however that, in those incurable patients, there is not a place for palliative chemotherapy and radiotherapy. As a matter of facts, with the use of supportive care techniques, relatively aggressive palliative therapy of neoplasia, and even experimental therapy, can be given to patients with advanced tumors.

However, such a therapy may not be reasonable beyond certain limits; this is the case when the performance status is low, the life expectancy is short or when treatment is declined by the patient. Under these circumstances, it is often appropriate to decide that cardio-pulmonary resuscitation will not be performed. However, this does not necessarily imply that all supportive care interventions should be automatically withdrawn and that these "not to be resuscitated" patients should only receive treatments which make them comfortable. Many of these patients can benefit from adjusted palliative therapies in combination with supportive care techniques.

Nevertheless, to avoid overtreatment which can occasionnally lead to a significant reduction of the quality of life in these patients, a try and evaluate approach is proposed; this implies that interventions will be discontinued as soon as their inconvenience outweights the benefit, rather than to palliate these adverse symptoms with new interventions.

It is clear that this comprehensive approach needs to take into account the patient's will and the medical possibilities. It would be unacceptable to treat an unwilling patient or to administer futile therapies.

1007

Patient needs as analysed through national "helplines"

Lilly Christensen. *Secretary General, Norwegian Cancer Society, Oslo, Norway*

Purpose: In order to improve patients-physicians relationship, ECL (European Cancer Leagues) has asked for a survey on this theme.

Methods: A questionnaire was handed out at the Helpline Conference in Granada, Spain, 2–4 May 96 to receive information on the types of problems the conference-delegates, who answer the helplines, have been running into regarding this special matter while speaking with patients or family members.

Results: 33 helplinedelegates from 23 European countries answered the twelve questions. I will present the results of this questionnaire. Other problems, not mentioned in the questionnaire, will be added.

Conclusion: There is a problem identified: Lack of good communication: it has to be taken seriously.

1008

Nordic cancer union: Programs in communication a way to increase patients satisfaction

Steinar Hagen. *Dept. of Oncology, Ullevål Hospital, Oslo, Norway*

Purpose: How to increase doctors skill in communication?

Method: A standard teaching program has been tested in 5 Scandinavian countries. One teacher and 6 doctors in each courses has been fulfilled.

Result: All course attending doctors has been evaluated. There is a high scar (increase) in the ability to communicate. 20 items are tested and the results will be revised.

Conclusion: The result is inspiring The Norwegian Cancer Society (one member of NCU) has put the program on their main agenda for the coming years.

1009

What's up doc? – A patient's perspective on Doctor/patient communication

Stephen H. Gold. *Glasgow Scotland, UK*

The presenter is a former patient, treated successfully for testicular teratoma. He is a lawyer by occupation.

Arising from my personal experience as a patient, the following issues seem to be the most important:

(1) Prior consideration of the personality, background, intelligence, social circumstances and state of knowledge of the patient.
(2) The need for training and self-knowledge in the Doctor as to his ability to communicate effectively.
(3) The need to listen and really hear the patient's response – the importance of body language, tone, the undercurrents of questions and "the questions not asked".
(4) Often, patients do not hear or interpret properly what is said to them. There is likely to be a need for continuous reinforcement.
(5) The need to have the whole caring team will briefed on the patient's understanding of his condition, his attitude to it and his concerns.
(6) The need for appropriate optimism, reassurance, warmth, humour and "small talk."
(7) The only golden rule is that there is no golden rules.

1010

Informed consent & cancer clinical trials

Baum Michael. *University College, London Medical School, Dept. of Surgery, Riding House Street, London, UK*

All agree that the randomised controlled trial is the gold standard for evidence based medicine. All agree on the ethical imperative for informed consent prior to recruiting patients into such trials. Most agree that the informed consent charade is the major rate limiting factor in improving statistical power of these clinical trials yet few are prepared to confront head on this dilemma. It is my view that the time for individuals to be informed