ment, 2) transcultural nursing education program for Italian and U.S. health care institutions, 3) multicultural/multilingual breast cancer education and support group, 4) culturally, sensitive public education program, 5) partnership among breast cancer advocacy groups. The process of needs assessment, program development, implementation and evaluation are discussed. Several areas for research are identified including patient satisfaction and quality of care, perception of adequacy of care, outcomes of treatment, and nurse satisfaction. The role of the oncology nurse specialist as program coordinator is reviewed.

295 POSTER

The Canadian Breast Cancer Initiative

B.A. Mathieu, L. Françoise Bouchard, M.P.H. Suzanne Inhaber, P. Mickelson, J. Parboosingh. *Health Canada, Adult Health Division, Population Health Directora, Postal Locator 1910 CI, Tunney's Pasture CDN-K1A 1B4 Ottawa, Ontario, Canada*

In December 1992, the Canadian federal government launched the Canadian Breast Cancer Initiative (CBCI) with funding of $25 million over five years, to build partnerships and networks to enhance research, prevention, care and treatment, professional education and information exchange on breast cancer. The CBCI was based on the strengthening of existing partnerships, the development of new alliances and the involvement of consumers (breast cancer survivors) throughout the process. A second phase of the CBCI was announced by the Canadian federal government in April 1998, with funding totalling $35 million over the next 5 years. The CBCI Phase II represents a balanced expansion of research and programs, building on the products, services and outcomes of CBCI Phase I, while incorporating the capacity to address new knowledge gaps and emerging issues related to breast cancer. It places emphasis on: increasing knowledge; dissemination and/or implementation of the lessons learned and products developed under the CBCI Phase I; strategies to increase the percentage and range of women participating in organized screening; dissemination of information to increase professional and public awareness; developing linkages across all activities of the CBCI Phase II; and, strengthened, independent evaluation of key products, services and activities to provide evidence of the most viable and effective strategies to address breast cancer issues. This presentation will discuss who is involved in the partnership, the major accomplishments to date, the activities underway and the policy implications for Canada.

296 POSTER

Breast cancer: The nurse's role in genetic counselling

Regina Ferrario. *Research Group INT/FIRC "Hereditary Tumours", Istituto Nazionale Tumori, Milano, Italy*

Although most people working in the field of medicine are familiar with the term genetic counselling, it is extremely rare to read a proper definition. The authors support the following definition: *genetic counselling is the process by which patients or relatives at risk of a disorder that may be hereditary, are advised of consequences of the disorder, the probability of developing and transmitting it and the ways in which this may be prevented or ameliorated:* (P:S: Harper, "Practical Genetic Counselling"). At least three major aspect are essential in genetic counselling: 1. The diagnostic aspect; 2. The actual estimation of the risk; 3. The supportive role of the nurse, in order to ensure that patients and their relatives will actually benefit from advice and preventive measures available. The National Cancer Institute of Milan promoted a survey to evaluate the chances of developing an hereditary cancer. 486 questionnaire were handed to women admitted for breast cancer. 456 (93.8%) were considered valid (no tumor or benign tumor were found in 80 Patients). Of the remaining 376 cases of malignant epithelial tumors 20.4% had a family risk. Sattin (1985) showed that at all ages first degree relatives of women with breast cancer had a 50% higher risk of developing the disease than other groups. When a family with an hereditary predisposition to breast cancer is identified, it is important to draw an accurate pedigree and inform women of the risks and the available choices. McGuire (1979) Albano and Lynch (1981) suggested that when specialized nurses are involved in the collection of family history, women appear to be more at ease and less defensive. The role of specialized nurses includes facilitating women to make informed decisions regarding treatment and helping them to cope with the uncertainty of the situation.

297 POSTER

Knowledge and beliefs about breast cancer prevention in an unselected female Italian population

R. Biamonte, S.F. Robbiati[1], O. Caffo[2], F. Tata[3], I. Sequi[4], G. Filippelli, A. Rovito, V. Liguori, S. Conforti, S. Palazzo. *Dept. of Oncology Cosenza; [1]Dept. of Oncology Rovereto; [2]Dept. of Oncology Trento; [3]Dept. of Oncology Sampierdarena; [4]Dept. of Anesthesiology Nuoro, Italy*

Purpose: We conduced a self administrered questionnaire to explore women's knowledge and beliefs about breast cancer prevention modalities.

Methods: We distributed this questionnaire to women entering several hospital units in Italy.

Results: Up to now we have collected 3715 questionnaires. In the sample 79.6% of women aged from 20 to 59 years, 78% had a medium-high educational level, 35.4% were housewives, 26.3% were smokers, 44.3% drank wine and 46.5% had almost one relative affected by a neoplastic disese. The information about prevention modalies was assessed as good in 36.7% questionnaires but the prevention was really prevention was really performed in a low percentage: 67.3% of the women knew about breast self-examination, 47.3% performed it but only 22.8% did it monthly; 49% of the women underwent a specialist visit once a year. In the last five years 31.9% of the women never underwent mammography. The main obstacle in performing breast cancer prevention exalinations was shows out of indolence by 34.4%, out of fear by 24.5%, for economic motives by 14.5% and and for lack of quick benefit by 3.8%. About 59% of the women thinks that the health authorities advertises the prevention too little and 81.5% that the main part of cancer prevention education should be carried out by health authorities (27.4% by school).

Conclusions: More enterprise is needed on the part of health authorities to improve cancer prevention.

298 POSTER

Patients' perceptions of routine follow-up after treatment for breast cancer and nurse-led clinics

E. Pennery, J. Mallett, J. Corner, G. Gui. *The Royal Marsden NHS Trust, England, UK*

Purpose: To ascertain patients' perceptions of medical routine follow-up after completion of treatment for breast cancer with a view to designing an alternative model for follow-up care.

Methods: Data of patients' views were collected using semi-structured taped interviews from a systematic stratified sample of patients attending medical follow-up clinics. These perceptions were inductively analysed and coded to ascertain predominant themes.

Results: A large proportion of the patients felt that the examinations were hurried and poor continuity was deemed unacceptable by 92% of the participants. The majority of patients felt uncomfortable expressing emotional concerns or asking questions. Three quarters of the sample stated that they would prefer to receive all or part of their follow-up from a breast care nurse.

Conclusion: Existing practice should be modified in light of resource implications and cost efficiency. On the basis of these results a prospective randomised trial has commenced to compare a nurse-led intervention with conventional medical follow-up for patients with breast cancer.

299 POSTER

Promoting healthy women

M. Lewis, S. DiMaria. *Breast and Endocrine, Surgical Oncology Unit, Royal Adelaide Hospital Cancer Centre, Adelaide, Australia*

The Women's Health Centre at the Royal Adelaide Hospital was opened in 1994 in recognition of the benefits of bringing together, under one roof, medical specialists and health care workers who deal with aspects of health care which are specific to women. The personal nature of many conditions experienced by women often means that the busy outpatient clinic in a large public teaching hospital is not an appropriate place in which to address these problems. In addition, the women's health services were fragmented within the hospital often requiring more than one visit for tests to be performed.

Housed in a refurbished heritage building, providing direct access onto a main thoroughfare, close to the city, the Women's Health Centre is on the periphery of the hospital campus without having to enter the main hospital building. This allows women access to advice, discussion, medical consultation, investigations and treatment, in one visit. Services include assessment of breast disorders, breast and gynaecological oncology, breast cancer