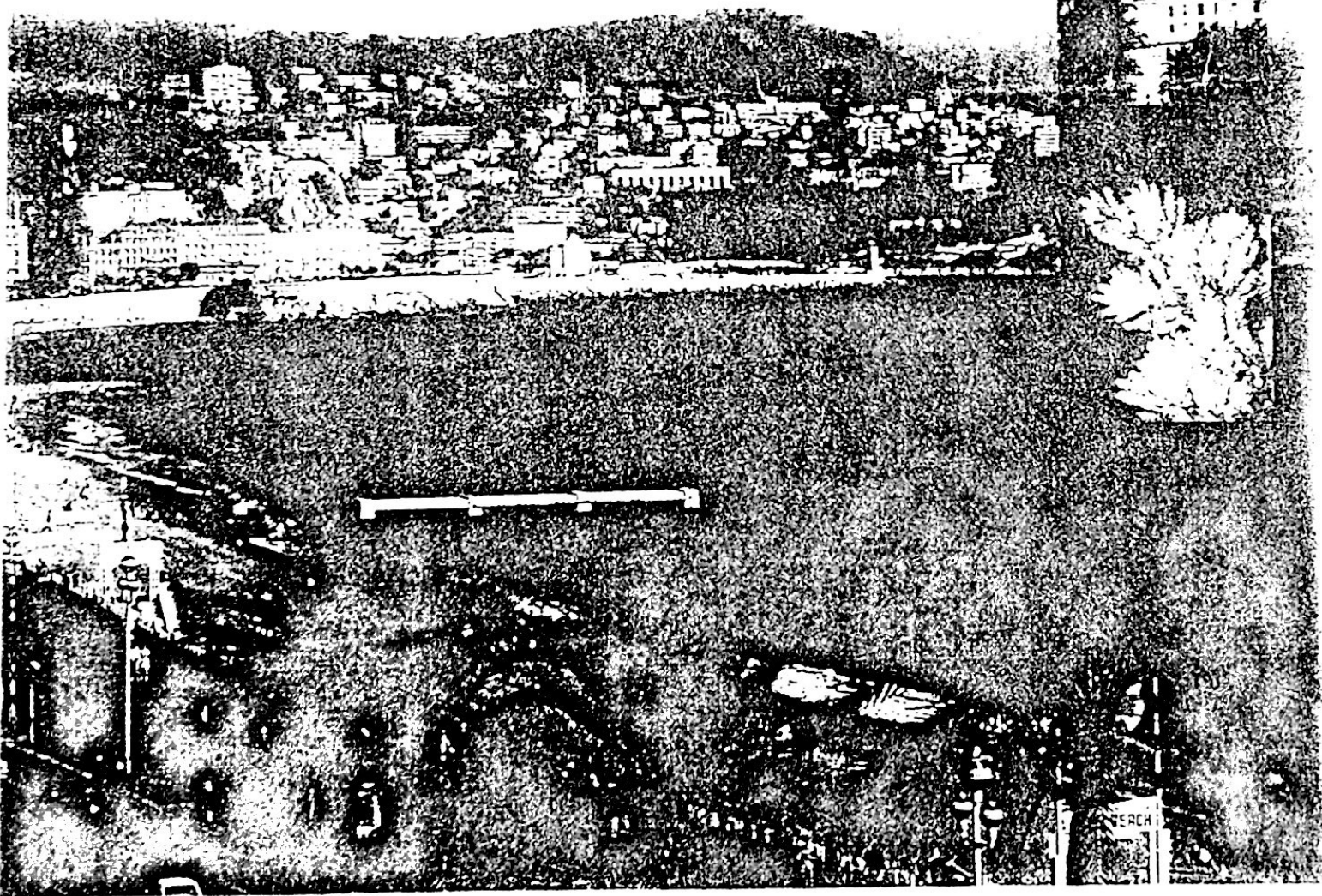


11TH MASCC INTERNATIONAL SYMPOSIUM

Supportive Care in Cancer

ACROPOLIS, NICE, FRANCE

FEBRUARY 18-20, 1999



Program, Talk Summaries and Abstracts

An INNOVATIVE Way of Caring: Palliative Radiation Therapy RAPID RESPONSE CLINIC

It is not uncommon for terminally ill patients to wait a few weeks to a month to receive palliative radiation treatment. The delays are due to lack of personnel and technological resources resulting in long waiting lists for radiation therapy. This gap in care was evident to all treatment center administrators, but their hands were tied due to economic constraints and continuing budget cuts.

With the timely expansion of Toronto Sunnybrook Regional Cancer Centre (T-SRCC), administration identified the provision of palliative radiation services as a priority in reducing suffering, due to very advanced cancer.

The Palliative Radiation Therapy Rapid Response Clinic provides clinic appointments within a few days, the services of a skilled interdisciplinary team and, if appropriate immediate radiotherapy to relieve distressing symptoms of advanced disease.

The implementation of the Rapid Response Clinic demonstrates a commitment to addressing the ongoing needs of the terminally ill.

ORAL PRESENTATION- 20 minutes in length
Poster- Photographs and statistics

RAPID RESPONSE RADIOTHERAPY PROGRAM-NEW APPROACH OF PALLIATIVE RADIOTHERAPY DELIVERY. ITS EFFICIENCY IN RETROSPECTIVE ANALYSIS *E. SZUMACHER, R. WONG, E. CHOW, C. DANJOUX, L. ANDERSSON, E. FRANSSEN TORONTO-SUNNYBROOK REGIONAL CANCER CENTRE, TORONTO, ONTARIO, CANADA

Background: In January, 1996, TSRC initiated the new form of delivery, palliative radiotherapy for patients with advanced cancer from Toronto vicinity called Rapid Response Radiotherapy Clinic. The objectives were to provide palliative radiotherapy consultation, simulation and treatment, in a single half day Clinic within 3 working days from referral.

Methods: Retrospective analysis from data base for administration utilization

Results: Since January, 1996 to June, 1998, we identified 374 records corresponding to 362 of patients seen in RRRP. Five Radiation Oncologists participated in this Clinic: 4 on weekly basis, 1 every 2nd week, 1 nurse, 1 pharmacist and 2 radiation therapists per session. Patients were referred from 13 Counties from Toronto's area, in majority by specialists outside Cancer Centre, by family physicians, and in small numbers by Oncologists from our Centre. 194 patients referred into the Clinic were seen within 3 working days as was planned. 310 patients required palliative radiotherapy after consultation. 255 of patients radiotherapy was delivered within 3 days from the consultation. The sites of primary were: Lung/Breast/GU/GI/Hematology/Endocrine/Others. Majority of patients were treated for palliation of bone metastases but other palliative problems were encountered as well. Different T/D/F schedules were used.

Conclusion: RRRP is an effective form of delivery Palliative Radiotherapy. T/D/F schedule for Palliative Radiotherapy needs to be standardized.

DEVELOPMENT OF LIFE-AFTER-CANCER CARE CLINICS TO ADDRESS THE UNIQUE HEALTH CARE NEEDS OF CANCER SURVIVORS. *Rena Vassilopoulos-Sellin, M.D., Norman, Jaffe M.D., Belinda Weatherly, R.N. The University of Texas M.D. Anderson Cancer Center, Houston, TX, USA

Advances in antineoplastic therapies are contributing to improved disease-free survival rates for patients who develop cancer. Cancer survivors, however, face unique health care problems because of their prior malignancy or their cancer treatment. Recognizing the special health needs of cancer survivors, we have initiated a life-after-cancer care (LACC) clinic designed to optimize the health care of former patients. At the present, the LACC clinic offers dedicated disease- and treatment-specific evaluation and treatment planning for survivors of breast and childhood cancers; focus is placed on metabolic, cardiopulmonary, physical, hormonal, musculoskeletal and psychosocial late effects. A database is established which enable us to describe the prevalence of physiologic, physical and psychological problems of cancer survivors and to compare them to persons without a cancer history. We can quantify the prevalence of cardiopulmonary and endocrine/metabolic abnormalities in LACC clinic participants prospectively and correlate such morbidity's with prior cancer therapies (e.g. cardiac vs anthracycline, endocrine vs radiation, gonadal vs chemotherapy). We can describe the amount of resources required to manage the physiologic, physical and psychosocial health needs in long-term cancer survivors and develop a model of the cost of providing these services using a resource-based strategy. We can assess health needs and associated costs of care tailored to detect and treat disease- and therapy-related dysfunction; prospective analysis of LACC clinic activities will yield information pertaining to cancer survivors care within currently available medical care delivery systems. Information about the prevalence and the amount of resources required to manage the physical and psychosocial problems of cancer survivors as well as their perceived need of intervention will allow us to better plan for the design and implementation of life after cancer care (LACC) programs and for the development of appropriate guidelines for health services addressing survivors' needs. Definition of cancer survivors' problems will allow us to anticipate such problems and to appropriately plan patients' follow-up and/or to modify current treatments hoping to ameliorate or minimize complications.

Conclusion: The initiation of the LACC clinic at MD Anderson will provide both cancer-specific care to cancer survivors and a setting for the acquisition of outcomes data. In addition, it can serve as a generalizable model for the health care of cancer survivors.

THE EVALUATION OF SOCIAL SUPPORT SYSTEMS, SELF ESTEEM, INTERPERSONAL SENSITIVITY, DEPRESSION AND ANXIETY IN PATIENTS WITH CANCER

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Background: Cancer is a stressful chronic disease inducing dependency, capability limitation and impairment to individual integrity. Disease-related feelings, social support sources, self-esteem and emotional states of cancer patients were examined in this study.

Methods: 90 inpatients at GATA Medical Oncology Department were interviewed face to face. Some social demographic characteristics, social support sources and emotional states of cancer patients were examined by interviewers. A modified Multi-dimensional Support Scale was used to determine the social support status of the patients whereas their emotional states were determined by using 3 sub-scales (interpersonal sensitivity, depression and anxiety) of SCL-90 (Emotional Signs Check-List). Self-esteem of patients was evaluated by the Stanley Cooper-Smith's self-esteem inventory. Results: It was determined that 100.0 % of the reassurance social support was provided by their immediate family, usually the spouses and children, 94 % of the support was of the emotional, 74 % tangible and 61 % informational social support. Mean self-esteem score of the patients was 69.11 (range 40-100). Mean interpersonal sensitivity score was 11.53 (range 1-32). Mean depression score was 16.35 (range 1-44). Mean anxiety score was 11.36 (range 0-31). The statistical analysis didn't reveal any significant relation statistically between social support and self-esteem.

Conclusion: The majority of the social support for the patients analyzed was provided by spouses and children. Their self-esteem, interpersonal sensitivity, depression and anxieties were noted to be low. Therapy programs should be devised according to the individual needs of the patients that may help decrease anxiety, anger, frustration and depression to the disease and treatment while enhancing self-esteem.