POSTER PRESENTATIONS

PD-01
THE ROLE OF VOLUNTEERS IN QUALITY PALLIATIVE CARE DELIVERY

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Introduction: Here in India almost 75% of cancer patients die a sad death of neglect due to lack of awareness about palliative care and low economic level. Surveys in India show that two-third of cancer patients do not get proper care during the terminal phase of their life. Palliative care through volunteers can make a significant difference in this respect.

Objective: To identify and try to solve, to the extent possible, the main difficulties in giving palliative care to the terminal cancer patients of the area. And evaluate the impact of direct care by volunteers on palliative care patients and their families.

Methods: Receive feedback from patients and their relatives regarding the palliative care they receive from nursing home and from volunteers and compare the two. Also feedback from volunteers regarding their positive and negative experiences while delivering palliative care service. Then evaluate the data to compare and improve the quality of service.

Results: We carried out two studies. One study was undertaken in nursing home palliative care and the other was in a home-setting by volunteers. Both studies were in adult palliative care services. Since January 2015, 496 cases were studied to enquire about their experience in both home-based care and nursing-home care. Both the studies fulfilled our quality appraisal criteria. One found that those families and patients who received home visits from volunteers were significantly more satisfied. The study highlighted the value of the role of volunteers in better satisfaction of patients and their families.

Conclusions: Further research is needed to evaluate the role of volunteers in palliative care and how it can be delivered appropriately and effectively. We also wish to compare our findings with similar studies elsewhere.

PD-02
BUILDING A NEW CORNERSTONE FOR PALLIATIVE CARE IN KERALA: A NURSING FELLOWSHIP

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Background: Palliative care is well developed in Kerala and is seen as an excellent model at local, national and international levels. Its doctors and volunteers are well trained. Its nurses would like more opportunities to develop their skills and role as agents of change. In response, the Institute of Palliative Medicine, based in Calicut, has begun work to develop a new fellowship in palliative nursing which could have significant impact in Kerala and beyond.

Methods: A group of nurses from Kerala with inputs from two UK-based senior nurses have been developing the programme of learning on which the fellowship will be based. They worked initially on a model of palliative nursing for Kerala and then a model of learning for the fellowship. Detailed work has been undertaken on the detail of the modules to be taught.

Results: The model of care is inspiring and draws on concepts of person-centred care to identify key outcomes to be achieved, nursing processes and qualities required. The programme of learning is also well developed and thoughtful. It is designed to facilitate the development of clinical nursing skills, underpinned by strong nursing processes and principles of palliative care. The modules draw on a similar fellowship for doctors, shaped to meet nursing challenges. Its approach to supporting learners is different to that used traditionally in India. It focuses on building strong self-assessment and self-learning, interpersonal skills, and a long-term network of peer support.

Conclusion: The fellowship in palliative nursing offers a new, but robust approach to the development of nursing. Work is underway now to pilot the programme and train the trainers. It will be of interest to nurses and others from across India and beyond, as an example of a new way to strengthen this important group of professionals in palliative care.

Key words: Education, Nursing, Palliative care

PD-03
STUDY THE IMPACT OF INVOLVEMENT OF COMMUNITY VOLUNTEERS IN IMPROVING THE QUALITY OF PATIENT CARE

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Introduction: Kerala is a place where neighbours lookout for one another, especially in the villages. This rare quality has led to the formation of the neighbourhood palliative care network on which the Kerala palliative care model is based. It recognises that for people with chronic and terminal illness, social support can be provided by trained volunteers supported by medical and nursing backup. The Neighbourhood Network in Palliative Care (NNPC) aims to empower the local community to look after the bed-ridden patients in their area to develop a cost-effective method for

the provision of palliative care in our settings. Pallium India was started in 2003 with the vision of providing quality palliative care service to patients in need of it. Pallium India is running a project in Trivandrum and also has helped in initiating palliative care centres and training centres in different parts of the country. Pallium India always believed in involving volunteers in providing palliative care, especially for home care which is an important component of palliative care. They have been involved right at the beginning of the project and have contributed much in terms of their valuable time and energy in order to provide quality care to the patients. Now the question is what kind of impact their contribution has made on the lives of the patients and their families and to what extent it has benefitted the volunteers. There has not been a systematic study on this subject so far and we feel it necessary to highlight the contribution made by these volunteers in palliative care. We hope this study will fill in the gap.

Objectives: Identify the role of community volunteers in improving the quality of patient care. We have 13 link centres attached to Pallium India. They are actively involved in providing home care services. In this paper we want to explore the reason for their motivation, factors that sustain them, problems they face and how they find solutions to the problem. Also, we want to know their perception of the role they play, their contribution in terms of time, quality of care, accessibility to patients and coverage.

Methods: Interview with volunteers of link centres using questionnaire, two respondents selected at random from each link centre, analysis of data and search of relevant published articles. Period of study: June to October 2015.

Outcome: Study the benefit of involving community volunteers in home care programme, identify weaknesses, suggest remedial measures, improve the quality of service provided to patients.

Conclusion: Here we are trying to identify the impact of involvement of community volunteers in improving the quality of patient care that includes development, evolution, benefits and weakness of it.

PD-04

QUANTITATIVE AND QUALITATIVE ASSESSMENT OF A VOLUNTEERS TRAINING PROGRAMME, ORGANIZED BY A HOSPICE IN UTTARAKHAND

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Introduction: The aim of the present study was to develop and conduct assessments (quantitative and qualitative) of Volunteers Training Programme (VTP) for socially active people to involve them in hospice work. No PubMed-based study assessing the percentage of participants, who actually volunteered after training was found. The study was conducted by Ganga Prem Hospice from September 2014 to August 2015.

Methods: A team comprising ten trained palliative care doctors, oncologists and nurses from the state of Uttarakhand and from abroad was formed to conduct these sensitization/training programs. Dates were finalized at the convenience of trainers and trainees. Tests were conducted before and after the training programme and paired T-Test was applied to find the statistical significance. After the sensitization/training programme the participants were asked to provide feedback for further improvement of the course.

Results: 350 non-medical socially active volunteers were sensitized and 57 participated in three VTPs organized. A total of 57 participants were trained in the three VTPs that were organized. Tests revealed that there was a significant improvement in pre and post test conducted for the participants. The average marks of 57 participants, pre-test were 2.75/5±1.04 and it increased significantly to 4.23/5±0.79 post-test. The qualitative assessment carried out through obtaining feedback about the course revealed that participants were willing to volunteer to provide assistance and reported that they had learnt a great deal regarding their ability to offer help to terminally ill cancer patients. They requested more case studies and wanted to visit a hospice and hospital. 10 out of 57 (17.5%) volunteers actually volunteered for the hospice after the training.

Conclusion: The medical team of Ganga Prem Hospice carried out a series of training programs on palliative care in order to generate volunteer support for the hospice. 17.5% participants volunteered. The need to improve the VTP by incorporating more case studies and a hospital visit was highlighted.

PD-05

REFERRAL PATTERN TO PALLIATIVE CARE SERVICES IN A TERTIARY REFERRAL HOSPITAL: SERVICE EVALUATION

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Background: Palliative care aims to relieve suffering in all stages of disease and is not limited to end of life care. Palliative services, including setting patient-centred achievable goals for medical care and aggressive symptom management, should be routinely offered alongside curative and disease-modifying treatments for patients with serious illnesses. The study was planned as a service evaluation to categorize the catchment areas of the specialty. The purpose of our study was to identify areas where we were failing to engage with other specialties and to recognize the areas of continuing medical education for the team.

Methods: A retrospective analysis of inpatient referral to the pain and palliative care team in a teaching hospital was done. The details of patients referred over a three-month period in a tertiary care hospital were taken from the electronic medical records. The study was done in an acute care setting in a hospital in Kerala. Data of 245 patients are being analysed.

Results: The interim analysis of the results indicates that a significant number of patients were referred for acute and chronic pain. There appears to be a steady referral from intensive care.

Conclusion: The pattern of referral could depend on the setting, location of the hospital and awareness among the specialists regarding palliative care.

Key words: Hospital, Non-cancer, Palliative, Services, Symptoms

PD-06

OUR EXPERIENCE IN VALIDATING THE FUNCTIONAL ASSESSMENT OF CANCER THERAPY-BRAIN-MLM

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Background: FACT Measurement System is a collection of health-related quality of life questionnaires in chronic illness. Quality of life is especially important in brain tumours and assessed using FACT-Br questionnaire. FACT-Br is used in 18 different languages including Hindi. However, this is the first attempt at validating a Malayalam translation.

Methods: FACT-Br has 21 items used alongside the general questionnaire. These items were first translated into Malayalam by two different people. The better of the two was chosen by a third person. This was then sent to a reverse translator who translated everything back into English. This whole work was sent back to FACIT. The original English was compared to the reverse translations and sent back with comments by FACIT. The Language Coordinator assessed the work, modified the reconciled translation where needed and occasionally made a new one. The FACIT comments/questions were answered by this person. After addressing multiple comments and concerns, the final translations were formatted into the questionnaire and sent back for proof reading. Then the testing documents were sent which we translated and tested in ten patients. The patients had to complete the questionnaire and then asked questions from the Patient Interview Form.

Results: The scores of the Malayalam translation were compared to the standardised English tool. The validation gave the sensitivity and specificity of the translated questionnaire.

Conclusion: The FACT-Br was validated in ten patients treated for brain tumours. Especially in patients with a borderline indication for treatment (most benign brain tumours), use of the FACT-BR-MLM might even help in the management decisions. However, obtaining the right patients (fluent in English and Malayalam with the ability to understand the purpose of the questionnaire and provide meaningful output) was the most difficult part. The process of validation itself emerged as a learning component in research studies especially for early researchers. The interaction with FACIT team was also an educational experience in qualitative research.

Key words: Functional Assessment of Cancer Therapy-Brain, Malayalam, Validation

PD-07

PAEDIATRIC PALLIATIVE CARE REFERRAL PRACTICES IN AN ONCOLOGY SETTING: A RETROSPECTIVE CHART REVIEW

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Background: Paediatric Palliative Care (PPC) is a growing specialty in India. There is limited information on PPC services which stands in contrast to the vast knowledge base on adult patient focused hospital-based palliative care. Also, extrapolation from adult focused studies to the paediatric population is thought to be inappropriate because of the distinctive patterns of life-threatening medical conditions in childhood. This study focuses on PPC referral practices in an oncology setting and uses the existing data sources in order to determine usage of specialist PPC services in a tertiary cancer hospital. Also, it will strive to decipher the complexities of shared decision making, seamless transition of care, desired locations of care, and ease the end of life for children who die at home in the Indian scenario.

Methods: Retrospective chart review of PPC registered with The Department of Palliative Medicine, TMC during the period 2010-2014. The following variables will be abstracted from the records: (1) demographic information, (2) clinical information, (3) characteristics of the palliative care assessment, (4) Liaison detail and (5) follow-up information. Using the final compiled master database, descriptive statistical methods will be applied.

Results: Ongoing study, results will come up by January 2016.

Key words: Oncology, Paediatric palliative care, Referral practices, Retrospective chart review

PD-08

USING A CONCERNS-CHECKLIST TO EXPLORE DIMENSIONS OF DISTRESS IN PEOPLE LIVING WITH HIV ADMITTED AT A PALLIATIVE CARE CENTRE

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Background: HIV care is largely focused on antiretroviral treatment and psychosocial issues are most inadequately addressed. People living with HIV deal with multiple issues and have various concerns from the point of diagnosis. At a time when they become acutely symptomatic or move to a terminal stage, many of these concerns are magnified and need to be addressed as part of Total Care.

Description: This poster describes how use of an adapted version of the Concerns Checklist developed by the National Cancer Survival network with patients admitted at Samraksha's HIV Palliative Care Centre over a two-month period led to a more comprehensive assessment and care of these patients. The Concerns Checklist was used by counsellors at the point of admission and at the time of discharge to explore physical, practical, emotional, social, economic, spiritual, religious and lifestyle-related concerns of the patient. It facilitated the care team to understand multiple dimensions of the patient's experience of distress and helped in responding to it.

Findings: The overriding concerns included fears for physical health, dealing with death and dying, fear of stigma and discrimination to the survivors resulting from disclosure of HIV status upon death, desire for reconciliation with family, planning the future of children, settling of property and worries about the cost of treatment. The poster will present the level of change in the various concerns over the period of admission and share which concerns could be addressed and which were challenging. It will also present the strategies used by the palliative care team to expand the support structure to address these concerns.

Conclusion: The use of tools like the Concerns Checklist can help to comprehensively explore the various dimensions of pain and distress and ensure better care of patients.

Key words: Assessment, Concerns checklist, Emotional distress, HIV, Palliative care,

PD-09

EMOTIONAL DISTRESS AND SECONDARY TRAUMA IN HIV-POSITIVE PROFESSIONAL CAREGIVERS: COPING STRATEGIES

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Background: Samraksha has been running an HIV Palliative Care Centre in Koppal in North Karnataka since 2001, where several members of the staff are HIV-positive themselves. While empathy, increased understanding, and deeper concern for people living with HIV are definite benefits for patients at the centre, the HIV-positive professional caregivers often experience a high level of emotional distress. Patient histories often act as painful reminders of their own experiences, causing secondary trauma that is sometimes overwhelming, interfering in the caregiving. At other times, those working with patients at the end of life have to deal with death and dying on a regular basis. Sometimes and with certain patients, it triggers anxiety about their own health and future. This is reported particularly when dealing with patients whose life experiences echo their own. Professional caregivers sometimes also report difficulties in dealing with patients who show similarities with one of their loved ones.

Description: This poster will describe how some of the processes adopted by Samraksha's HIV palliative care centre help the professional caregivers deal with the issue. The processes include personal counselling, supportive supervision and debriefing, and regular grief and bereavement meetings. The poster will include reflections and strategies used by professional caregivers at the care centre, including journaling, separating their situation from that of the patients and maintaining boundaries and measures taken to cope with anticipatory anxiety and grief.

Conclusion: Recognizing secondary trauma and triggering of anticipatory anxiety in HIV caregiving and creating coping strategies for dealing with them is critical.

Key words: Coping, Emotional distress, Professional caregivers, Secondary trauma, Support systems

PD-10

PROJECT FOR EDUCATING MEDICAL AND NURSING STUDENTS ON MANAGING PERSISTENT PAIN THROUGH APPROPRIATE UTILIZATION OF WHO LADDER ANALGESICS AND INTERVENTION TECHNIQUES

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Introduction: The training programme focused on assessment and management of persistent pain, designed to sensitize and empower the undergraduate medical and nursing students towards patient care. It is estimated that less than 1% of the needy has access to pain relief in India. Even today, though the Medical Council of India has approved "Palliative Medicine" as a specialty, basic principles of pain management or palliative care are still not taught to undergraduate medical students. The state of Kerala is an exception because it has evolved a system of delivery of pain relief and palliative care so that about 40% of the needy have access to palliative care in Kerala. Acting on a proposal submitted by Pallium India in 2005, the Government of Kerala declared a palliative care policy in 2008. One of the objectives of this policy was "to develop and incorporate palliative care modules in medical, dental, nursing, pharmacy and paramedical courses". Though this was a short-term objective that should have been achieved by 2010, not much has happened in this regard. The lack of developed palliative care facilities in most medical colleges in the state and the lack of palliative care teachers is a major handicap that denies palliative care education to undergraduate students. This concept paper proposes an action plan for incorporation of "Principles of Pain Relief and Palliative Medicine" in the existing syllabus in all medical colleges in the state of Kerala. Thereafter, a corps of volunteer palliative care physicians is to be recruited from existing palliative care centres in the state so as to provide palliative care education even in medical colleges where palliative care services are unavailable.

Objectives: Describe assessment of pain; differentiate types and etiological basis of pain; evaluate a pain patient comprehensively; describe relevant pharmacology, indications, caution and practical usage of analgesics from WHO ladder; enumerate common intervention techniques available for managing persistent pain. Describe the fundamental criteria for choosing intervention techniques for a pain patient. Ability to refer to pain specialist when indicated.

Methods: We sent emails to the heads of all medical colleges in the country and also approached many personally wherever we had contacts. Eight institutions came forward and agreed to conduct the training on basis of geographical distribution primarily and secondarily on first-come first-served basis. We asked for final year medical students and those who were undergoing one year of compulsory rotating internship following 5 years of medical education. We shall monitor the impact of the training in 2016. This could be done through direct visit or through questionnaire. We can get feedback as to how the institutions used the knowledge gained about pain management and how the students have benefited from training. We expect that the majority of institutions will continue to provide the training on their own. In addition, we are continuing similar training in many medical colleges raising local resources. Eventually, this reaches out to a large, critical mass of young doctors in the near future. Topics included in the training are: Principles of palliative care, basics of communication, chronic pain, pain assessment, management of chronic pain, WHO analgesic ladder, adjuvant analgesics and intervention techniques.

Materials: An Indian Primer of Palliative Care which includes the manuscript on pain management, soft copies of the presentations, videos.

Outcome: We have conducted training for1053 over a year in 10 medical colleges in and outside Kerala.

Conclusion: This training programme increased the number of trained doctors and nurses in India.

PD-11

CONCERNS OF CANCER PATIENTS AND THEIR CAREGIVERS IN A PALLIATIVE CARE CLINIC

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Background: In busy tertiary care centres, although the physical symptoms of patients are well addressed, the psychosocial concerns and the needs of patients and their caregivers are often overlooked. The aim of the study was to assess the concerns of patients with advanced cancers and their caregivers on the day of referral to the palliative care clinic.

Methods: A survey was conducted on 140 subjects attending the palliative care clinic. These included 70 patients along with their caregivers (n=70). The patients were assessed for their psychosocial concerns and their information needs on their first visit to the palliative care clinic.

Results: The concerns of both the patients and the caregivers were separately documented. Pain followed by fatigue and insomnia were the most bothersome symptoms reported by the patients. While most of the patients (91.4%) wanted symptom relief, patients' life expectancy was a major concern of the caregivers. The other common concerns of the patients were the disease status and curability of the disease, whereas the caregivers were more concerned about the alternative treatment measures. Of the psychosocial problems, majority of them were related to financial concerns followed by settlement of children and loneliness.

Conclusion: A difference between the needs of patients and their givers was observed in the present study. This may be attributed to less focus on the psychosocial problems in the busy outpatient clinics. Psychosocial concerns and effective communication both with the patient and their caregivers is required to ensure holistic care.

PD-12

PALLIATION IN A PATIENT WITH OSTEOSARCOMA: A COLLECTIVE EFFORT

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Background: A 16-year old female patient with left tibial osteosarcoma was refereed to our hospital for palliative care from Pondicherry in collaboration with Tamil Nadu Institute of Palliative Medicine, Cuddalore due to lack of facilities for end-of-life care, in June 2015. The patient had multiple social and financial issues leading to repeated default in treatment at Pondicherry over the last one year.

Methods: Lakshmi Pain and Palliative Care Trust is a hospital based palliative care unit which provides OPD, IPD and home visit facilities. Upon referral, baseline haematological investigations for the patient revealed chronic anaemia. All other investigations were within normal limits. The patient was provided pain relief, wound care and nutritional support free of charge for three days. The overall condition of the patient improved tremendously under our care. However, due to the advanced nature of her disease, we anticipated that her end was near. Since our hospital is not permitted to handle last rites, we transferred the patient to RMD Hospice, Chennai where the patient continued to be comfortable till she breathed her last a week later.

Conclusion: Palliative care is a multi-dimensional endeavour where in-patient, out-patient and community outreach facilities need to run in tandem. No single model of care can be conceived as the ideal. The emphasis for end-of-life care needs to be on continuity of care and support irrespective of social and economic background.

Key words: Co-operation, Co-ordination, Initiative, Networking, Palliation

PD-13

KNOWLEDGE AND PERCEPTION OF PALLIATIVE CARE AMONG NURSES WORKING IN A CANCER HOSPITAL

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Studies have documented that insufficient knowledge of palliative care among nurses is one of the main obstacles to providing quality palliative care services. This study aims to evaluate nurses' knowledge about palliative care at a tertiary care centre. It was intended that the study would be able to stimulate discussion about the provision of palliative care, measure and compare different groups' level of knowledge, and identify their most frequently held misconceptions about morphine and palliative care practices.

Design: Cross-sectional study of staff nurses working in a cancer centre.

Methods: A survey was conducted using questionnaire PCKT developed by Nakazawa et al. which had 20 items (statements about palliative care) for each of which the person had to indicate correct, incorrect or unsure. The PCKT had 5 subscales: philosophy 2 items, pain 6 items, dyspnoea 4 items, psychiatric problems 4 items and gastrointestinal problems 4 items.

Results: Will be presented at the conference.

Key words: Information, Nursing education, Palliative care education, Professional knowledge

PD-14

AN EXPLORATIVE STUDY TO ASSESS THE SPIRITUAL ISSUES AMONG MOTHERS WITH CHILDREN RECEIVING PALLIATIVE CARE

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Background: There are children who are born with congenital deformities or later develop chronic conditions, which are associated with lower mortality rates and significantly higher morbidity levels. These children continue to live longer lives than before due to the advances and strides we have accomplished in the field of medicine. A study was conducted to understand the spiritual aspects of mothers with children receiving palliative care along this trajectory so as to make a training module to manage spiritual issues.

Objectives: To explore spiritual issues of mothers with children receiving palliative care, to identify the needs, issues and problems of mothers and to prepare a training module which can be used by health care professionals working in palliative care.

Methods: After obtaining consents, an in-depth interview was conducted with ten mothers in multiple sessions and qualitative analysis was utilized to explore the human experience and identify themes. All mothers expressed few common themes: "I trust in God's plan." "Questioning God." "God is everywhere but not here." "Why God, why this to me?" "God will answer me some day." "God gives sufferings to his loved ones." "God has a plan." "I can't believe in God when my child is crying." "God, when this will get over?" "God, please take me away along with my child." "God, I can't handle this anymore." "Why you gave him poor health?" "God what should we do?" "God, I will do anything to get my child back', "Take my life and bless my child with good health." "I believe in miracles and I'm sure God will do the best for my child." "Please don't take my child from me." The essence of the spiritual experience of having a child receiving palliative care was to understand the meaning of suffering and to regain a control over the situation.

Results: The results of this study challenge health care professionals to be conscious of the nature and difficulties faced not only by patients face but also by family members, especially mothers. The study can increase the understanding of spiritual issues. It is clear that we as health care professionals should also assess the spiritual dimension with utmost importance and we should be trained to deal these issues in the right way and provide comfort always.

PD-15

MIRTAZAPINE AN EFFECTIVE THERAPY IN PALLIATING CANCER ANOREXIA IN ADVANCED PROSTATE CANCER WITH COEXISTENT RENAL FAILURE

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Introduction: Terminally-ill cancer patients (TICP) often suffer from anorexia, which is frequently resistant to treatment. Patients with advanced prostate cancer have coexistent renal failure which accentuates anorexia and makes its management challenging. Because of its complex origin no specific therapy for cancer anorexia is known. The tetracyclic antidepressant mirtazapine, frequently used in TICP is also known to induce hunger and weight gain in healthy volunteers.

Aim: Evaluate the effect of mirtazapine on cancer anorexia in presence of renal failure.

Methods: Twenty-six metastatic prostate cancer patients having serum creatinine level >1.8mg % (2.45 ±1.32 mg%) complaining of mild to severe anorexia and associated weight loss was included. All the patients reported weight loss of more than 5 kg over the previous 4 months. Past dietary intake was recorded and compared to their current dietary intake. All the patients were put on once-daily dose of 7.5mg mirtazapine orally. They were followed up at 2-, 6- and 12-week intervals. All 26 patients could complete 2-week follow-up and 24 patients could complete the entire study period.

Results: Mirtazapine promptly (within 24 hours) induced appetite in 21(80.7%) patients, 5(19.2%) patients reported no benefit. No further weight loss was noted in any of the participants. Weight gain was over 2 kg over the 12 weeks' observation period in 19 patients, whereas 2 patients reported weight gain over 3 kg. Most of the patients reported of increased somnolence and tremors during the first week of therapy, which was self-limiting and did not warrant any dose modification or dug withdrawal. No significant change in pre- and post-therapy serum creatinine value was noted during the study.

Conclusion: Mirtazapine is safe and effective in promoting appetite and inducing weight gain in terminally ill advanced prostate cancer with coexistent renal failure.

PD-16

PATIENT'S DECISIONAL CONTROL PREFERENCES IN THE PALLIATIVE CARE SETTING: A MULTI-CENTRE SURVEY

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Background: Communication forms an important aspect of providing effective palliative care. It is important to encourage patient's autonomy and participation in medical decision making. Increasing awareness of health care professionals about patient's preferences for decision making will improve the quality of care, thus improving patient and caregiver satisfaction. Hence, it is important to have baseline information about the patient's preferences for decision making to improve patient-family-physician communication.

Objectives: To determine the agreement between patients' decisional control preferences and their self-reported actual decision-making experiences regarding cancer care, to identify the factors that influence patient satisfaction with the decision-making process, to determine patient's level of understanding of their illness and prognosis.

Methods: Participants were asked questions regarding their treatment decision-making preferences. Interviews were conducted at the time of participants' enrolment for the study. Descriptive statistics, spearman's correlation and multiple linear regression were used to analyse the data.

Results: Patients' decisional control preferences and their self-reported actual decision-making experiences regarding cancer care, are significantly correlated to each other r=0.648 (p?0.001). According to the regression table, the variables that are significantly related to patient satisfaction by the way of decision making are patient satisfaction about information received (r=0.548) and decisions about their care (r=0.203) (p?0.05). [R^2=0.641, ANOVA (p?0.001)]. It was found that patients had no clear understanding of their illness and prognosis as 70% responded saying their cancer was curable. With respect to current health status, 85% reported of being relatively healthy and 67% reported that they were seriously ill and not terminally ill.

Conclusion: There is good agreement between patients' decisional control preferences and their self-reported actual decision-making experiences regarding cancer care. Factors that influence patient satisfaction with the decision-making process are satisfaction with information received and decisions about their care. Patient's level of understanding of their illness and prognosis is poor.

Key words: Communication, Decisional control preferences, Quality of care, Understanding of illness and prognosis

PD-17

FREQUENCY DISTRIBUTION OF GENETIC POLYMORPHISMS IN GENES ASSOCIATED WITH OPIOID IN CANCER: INDIAN SCENARIO

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Introduction: Control of pain and side effects of opioid in cancer pain patients is paramount to clinical success in caring for patients with advanced cancer. Opioids are used to treat acute and chronic, moderate to severe pain, with morphine being recommended by WHO. Genetic variations contribute to differences in pain sensitivity. Genetic variation in genes OPRM1, ARRB2, COMT, UGT2B7 AND MDR1 have been suggested to contribute to inter-individual variability regarding pain sensitivity and opioid use in patients with chronic pain in cancer.

Objective: Find out the frequencies of genetic polymorphisms in Indian cancer pain patients, who were taking morphine.

Methods: Patients who are on chronic oral morphine are being included in this study. Pain is measured using Visual Analog Scale (VAS). Total 250 subjects will be randomised into test and control group (Control group VAS = 0-3 and test group VAS = >3). 10ml peripheral blood is collected in EDTA vaccutainer and Peripheral Blood Mononuclear Cells (PBMC) is isolated using density gradient centrifugation method. Genomic DNA is isolated from PBMCs. Genetic variation in genes of interest is evaluated using sequence specific primer PCR. The genotypes of rs6912029, rs9479757, rs2075572 (OPRM1); rs1045280 (ARRB2); rs7438284, rs7439366 (UGT2B7); rs1128503, rs2032582, rs1045642 (MDR1) and rs4680 (COMT) are determined by SSP-PCR (sequence specific primer-polymerase chain reaction) in 250 patients with cancer-related pain. Genotype frequencies were found out with Chi-square test.

Results: In 250 patients, frequency of genotype GT in OPRM1 -172G>T, heterozygous AG in OPRM1 IVS2+31G>A, variant CC in OPRM1 IVS2+691G>C and homozygous GG MDR1 G2677T/A is higher in our study as compared to Caucasian population.

Conclusion: The frequencies distribution of polymorphisms for ten SNPs in OPRM1, ARRB2, UGT2B7, MDR1 and COMT genes have generated baseline data for future studies on the role of these SNPs in the pharmacokinetics or pharmacodynamics of opioid used for pain management in cancer patients.

Key words: Cancer, Genetic polymorphism, Morphine and pain

PD-18

CAPACITY BUILDING IN PALLIATIVE CARE THROUGH HUMAN RESOURCES DEVELOPMENT AT TERTIARY CANCER HOSPITALS

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Background: Less than 1% of India's population has access to palliative care. Approximately 10 lakh new cancer cases are diagnosed in India every year and of those 60% - 80% need palliative care. Factors hindering the growth of palliative care include lack of trained palliative care staff, poverty, lack of infrastructure to provide palliative care and restrictive national policies regarding opioid prescription.

Methods: Since 2010, Jiv Daya Foundation (JDF) has been supporting human resource development in the form of doctors, nurses, social workers and data managers to build hospital capacity and establish dedicated palliative care clinics. Depending on their position, staff members are responsible for running palliative care OPDs, psychosocial assessment of patients, fundraising and entering data into the online palliative care registry (ICanR). JDF has supported 84 staff after needs assessment of 25 hospitals and 3 NGOs across India between 2010 and October 2015. JDF also provided palliative care training to a number of staff and expanded its support to provide free oral morphine tablets to hospitals. Outcomes of these projects were measured on the basis of number of patients receiving palliative care services, opioid accessibility and usage, and data management.

Results: Of the 25 hospitals, 18 are successfully running dedicated palliative care OPDs on a daily basis and more than 59,549 patients have received specialized palliative care. JDF has provided a total of 3,75,500 oral morphine tablets to 7 major hospitals.

Conclusion: Capacity building in palliative care through human resource development at tertiary cancer hospitals improves number of patients receiving palliative care services, accessibility and usage of opioids and data management. Retaining staff and sustaining palliative care services will be a challenge until permanent positions for palliative care are created.

Key words: Capacity building, Human resource development, Palliative care

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PD-19

COPING STRATEGIES IN ADVANCED CANCER PATIENTS REFERRED TO PALLIATIVE CARE CLINIC IN A TERTIARY CARE CANCER HOSPITAL: FIRST PHASE OF A RETROSPECTIVE AUDIT CYCLE

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Introduction: Although guidelines exist for psychological assessment in patients on palliative care, no specific recommendations for standards are available pertaining to assessment of coping strategies. We conducted an audit exercise (1) to determine whether the coping strategies of adult advanced cancer patients newly referred to our palliative care service are being assessed and documented on their first consultation, according to our service standard (set at 60% of all included forms, following discussion with senior faculty), (2) to note types of coping strategies documented, and (3) identify problems/barriers in process.

Methods: Patient assessment forms of the first consultation of advanced cancer patients referred to palliative care services over a one-month period were retrospectively analysed. Those forms in which psychological assessment was not recorded, were excluded. Data was collected about documentation of coping strategies and types used, as outlined in the forms. Descriptive statistics were noted for documentation in forms and types of coping strategies used. Problems/barriers in documentation were identified.

Results: 186 out of 317 assessment forms fitted the eligibility criteria of documentation of psychological evaluation. Coping strategies were recorded in 140 out of 186 forms, i.e 75.3%, higher than the set standard of 60%. The assessed coping strategies documented in the forms (from higher to lower frequency) were acceptance, seeking support, denial, problem solving, controlling, confronting, distancing and avoidance. Non-completion of all sections of the assessment forms was a significant problem. This study pertains only to the first phase of the audit cycle.

Conclusion: Our set standard of documentation of coping strategies was met in the first phase of our audit cycle, which identified the types, problems and barriers in the recording process. The next phase of the audit would aim to implement changes and repeat the process, as standards-based audit in an essential component of specialist palliative care service.

Key words: Audit cycle, Coping strategies, Palliative care, Standards

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PD-20

EVALUATION OF PSYCHOSOCIAL ASPECTS IN ADVANCED HEAD AND NECK CANCER PATIENTS

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Introduction: Advanced head and neck cancer (HNC) patients need a lot of attention from the physician and the family. A palliative care physician needs to understand the psychosocial requirements of these patients and then ensure that the patient and family understand the disease process and its requirements in its entirety.

Objectives: To assess the psychosocial aspects of advanced HNC patients during palliative care.

Methods: Data was collected from case records and telephonically from the patients/caregivers, regarding symptoms burden and the management in order to identify psychosocial factors that may affect care. Multiple counselling sessions were conducted to train them for home-based supportive care, prepare for the inevitable and ensure pain-free and peaceful death. Data was analysed as of September, 2014.

Result: 153 HNC patients were seen from January 2013 to August 2014. Out of these, 139 (91%) were male with median age of 52 years. 90 (59%) patients needed various degrees of assistance for their routine day to day care. 78 (55%) were daily wagers and having income below Rs 5000 per month. Median distance travelled to come to palliative clinic was 108Km. Nearly all of them were living with their family. Despite family support, 53 (35%) had poor motivation towards life, at the time of presentation. 61 (40%) had disturbed sleep either because of pain or/and anxiety. Pain was the most common presenting physical symptom in 134 (87%), which was managed effectively in 112 (84%) patients. During the terminal phase of life, 30(44%) out of 62 documented cases, had depression and one patient even tried suicide thrice in spite of counselling at each and every visit. At the time of analysis, 109 (71%) were dead and 54 (50%) had breathed last at their home, the place where they actually wished to die. Nearly all these were peaceful deaths (as reported by their care givers). In 46 (73%) their near ones were prepared for the terminal event.

Conclusion: These patients had several issuesfinancial, travelling, emotional trauma, nutritional, pain, fistula/fungation etc. Proper symptom management and repeated counselling managed to alleviate these issues in a cost-effective manner in these advanced HNC patients.

PD-21

EMPOWERING NON-MEDICAL HEALTHCARE WORKERS TO IDENTIFY THE NEEDS OF CANCER PATIENTS

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Background: Cancer is responsible for 6% of deaths in India. The morbidity caused by cancer is responsible for the loss of around 8.7 million DALY, second only to ischaemic heart disease and more than diabetes and stroke. Many of the cancer patients after initial treatment spend their last days at home, usually without significant medical care. The study was conducted as part of a locally-run Cancer Prevention and Control Programme to identify the status of the cancer patients in the community served by our institute.

Methods: Study was carried out in the 60 villages of Anand and Kheda districts of Gujarat state. All the cancers patients in the study villages, irrespective of place of diagnosis or treatment status were interviewed at their home by the field workers trained to make basic assessment of the patient. The data was entered in Epi-Info version 7 software and analysed using SPSS version 17 software. Project was cleared by the institutional ethics committee.

Results: Of 167 patients interviewed 96 (57.5%) were males, 148 (88.6%) were currently married, 44 (26.3%) had some kind of health insurance coverage, 14 (8.4%) were also using alternative medicines especially Ayurveda. Of all the patient examined 31(18.6%) were asymptomatic. Pain (56.3%), difficulty in swallowing (29.3%) tiredness (28.1%), sleeplessness (20.4%), and cough (16.8%) were the commonest symptoms.

Conclusion: The trained non-medical workers can be empowered for identifying the needs of the cancer patients during their routine visits for other data collection.

Key words: Cancer, Primary healthcare worker, Symptom assessment

PD-22

FACTORS ASSOCIATED WITH PLACE OF DEATH IN PATIENTS OF ADVANCED CANCER REFERRED FOR PALLIATIVE CARE IN THE INDIAN SOCIO-CULTURAL CONTEXT

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Background: Use of hospital resources can be expensive and inconvenient for terminally-ill advanced cancer patients, compromising their quality of life while also increasing the burden on healthcare system. The growth of palliative care has provided options for these patients to die at a place other than the hospital. There is a gap in evidence for factors influencing place of death of advanced cancer patients in the Indian population. The purpose of this study is to assess factors associated with the place of death (home/hospice/hospital) in advanced cancer patients on palliative care.

Methods: The study design is retrospective observational. Patients included were those with advanced cancer registered with Department of Palliative Medicine, Tata Memorial Centre, who expired between July 1 and Oct 31, 2015 and had knowledge about and access to home care, hospice care as well as hospital. Data was collected on demographic, socio-economic and clinical details, acceptance of prognosis, duration of palliative care, number of home care visits and symptom severity at end of life. Descriptive statistics were used for overall data, and Chi square/Fisher's exact test was applied to interpret association between categorical variables.

Results: 31% of total 142 patients enrolled for study died in hospital. Non-acceptance of prognosis by caregivers (p=0.015), higher patient education (p= 0.02) and good financial condition (p=0.03) were significant factors associated with death in the hospital. Significant number of those who died at home had non-distressing symptoms at the end of life (p=0.01) while those with non-supportive family died in the hospice.

Conclusion: Acceptance of prognosis by caregiver and good symptom control at the end of life are important modifiable factors which decide the place of death. Addressing these during palliative care of advanced cancer patients, may help prevent death in hospital and thus improve their quality of life.

Key words: Advanced cancer, Palliative care, Place of death

PD-23

IMPACT OF HOME PULLEY SYSTEM IN MANAGEMENT OF LYMPHEDEMA: IMPACT ON HEALTH OUTCOMES AND COSTS

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Background: In recent years, due to the increase in the incidence of cancers and modalities of treatment, research on the physical and psychosocial impact of both has intensified. Lymphedema is a common complication in such individuals. Functional changes associated with lymphedema include reductions in the movement of the affected limbs and increase in the body segment volume. This frequently is associated with pain and consequently alterations in the quality of life and difficulty in performing everyday activities. Physical therapy, bandaging, compressive garments, and pneumatic compression devices (PCD) are used to reduce lymphedema in the intensive phase of management. The most important aspect of management, however, remains limb elevation. Providing support in this regard at home has been an unexplored territory. Yet, the economic impact of its treatment can be very significant. Innovative methods of managing lymphedema at home by educating and empowering loved ones to care will help patients to live better, healthier lives.

Objective: To investigate whether the use of an advanced pulley system device at home was associated with improved clinical outcomes and costs in a representative population.

Methods: Patient received in-home education about the pulley system, its use, safety precautions, and attending to any complications. A phone number was provided for immediate contact as required. Clinical outcomes assessed were decreased hospitalizations or clinic visits, prevention of infections and socio-economic impact.

Results: Patients and their families using the pulley system were satisfied with the device and perceived it to be beneficial in terms of social and economic outcomes and compliance towards the management of their lymphedema.

Conclusions: By using this pulley system device at home patients can have good quality of life with better outcome.

Key words: Lymphedema, Pulley system

PD-24

STUDY OF RESILIENCE AND ITS RELATION WITH QUALITY OF LIFE IN CAREGIVERS OF PATIENTS WITH ADVANCED CANCER REFERRED TO PALLIATIVE CARE SERVICES

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Background: Caregiver wellbeing can influence family function and quality of life and physical health. Research has shown that resilience i.e. one's capacity to recover from extremes of trauma and stress is directly related to quality of life. There is a lack of studies in developing countries addressing resilience and its relationship with quality of life in caregivers of patients with advanced cancer.

Aim: To assess resilience and its relationship with quality of life in adult caregivers of advanced cancer patients receiving palliative care.

Methods: A cross-sectional study was conducted in primary adult caregivers of patients with advanced cancer referred to palliative care clinic at a tertiary cancer care centre. Using convenience sampling, 30 caregivers were interviewed recording basic socio-demographic data, Connor-Davidson Resilience Scale (CD-RISC) questionnaire and WHO-QOL BREF questionnaire in their preferred languages. Data was analysed using SPSS v.20 for descriptive statistics and tests for correlation between resilience and quality of life.

Results: Out of 30, 29 participants filled the questionnaires. There were 23 males (79%) of which 13 (44.8%) were sons. The mean age was 36.24 years (SD±9.9). The mean and SD for resilience score was 70.10±16.47 and Quality of life (QOL) score was 14.96±3.00. Pearson correlation coefficient between resilience and overall QOL was 0.46 (p= 0.012) and with social relation domain of QOL was 0.52 (p=0.004). Males (71.70 vs 64.00) and graduates (76.25 vs 67.76) had higher resilience score, though it was not statistically significant.

Conclusion: The present study suggests that adult caregivers had good resilience. There was statistically significant correlation between resilience and social domains of QOL. Identification of resilience and appropriate psychosocial interventions to enhance resilience will be useful to improve caregivers' quality of life in a developing country context, both in clinical work and research.

Key words: Care giving, Psychosocial issues

PD-25

KARAYA POWDER: COST-EFFECTIVE NATURAL REMEDY FOR PRESSURE ULCERS

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Background: Pressure ulcers are common in cancer patients and are associated with adverse health outcomes, with a major impact on an individual's quality of life and leading to high treatment costs. Proper nutrition, pressure redistribution, and local ulcer care form the mainstay of treatment. Most dressings available are expensive and in a resource-poor setting difficult to afford. In addition, ulcers in the sacral and ischial area are difficult to dress and keep clean due to their location. Although Karaya powder has been used in stoma care, there is very little published data on the use of Karaya powder for the treatment of pressure ulcers.

Methods: The aim was to estimate the efficacy of Karaya powder on Grade I and Grade II pressure ulcers. Inpatients with pressure ulcers were assessed for the grade of pressure ulcer. Patients, who had Grade I or Grade II ulcers, were provided with information regarding the various dressings available. Those who chose to use Karaya powder were included in the study. They were educated in detail on the process of mixing the powder to form a paste and application of the paste on the ulcers. Application of the prepared paste was recommended each time perineal care was required. The patients and carers were educated regarding personal care to prevent ulcers according to the gold standards.

Results: The result clearly demonstrates the cost-effective, patient-friendly and healing properties of Karaya powder. It was accepted well by the patients. The improvement of the pressure ulcer was visible on a daily basis and this ensured better compliance to other supportive measures for pressure ulcers.

Conclusion: Karaya powder is a natural hydrocolloid, having unique skin care properties. It protects raw and weeping skin and is of great value in treating pressure ulcers especially in the sacral and perineal areas.

Key words: Care giving, Psychosocial issues

PD-26

VOLUNTEERS' MAGIC (ROLE OF VOLUNTEERS) IN BRINGING LIFE TO DAYS OF TERMINALLY ILL PATIENTS

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Background: Patients who are terminally ill with an advanced disease are mostly home-bound, and they go through each day, depressingly, which brings them closer to the inevitable. It is at this time they usually look up to someone to talk to or just be with them for some time. A volunteer's role at this point is not only to be a helping hand for the family, but a person who communicates empathetically to the patient.

Objective: Highlight the role a volunteer plays in the life of a patient suffering from a life-threatening illness. This poster will show the ways in which the volunteers at Department of Palliative Care, Bhaktivedanta Hospital, Mumbai, have created magic through their hard work and compassion.

Methods: Prior to patient visits and interaction with patients, the volunteers receive training in communication skills, psychology of patients, and how to approach terminally ill patients. Currently we have 52 volunteers who are mainly arts and science graduates from various colleges. The volunteers provide diversion therapy, wish-fulfilling activities, manage events, assist family caregiver in daily chores, take care of pets, celebrate festivals, cook for patients, celebrate patients' special occasions and give respite care where needed.

Conclusion: Volunteers' help has enabled our patients to accept their situation, has reduced psychological pain, and provides a ray of light in the darkness of hopelessness. This poster presentation is an endeavour to encourage and appreciate the efforts of our volunteers, which will engage, educate many more people from community to become volunteers and help the terminally ill patients.

Key words: Community care, Diversion therapy, Volunteers

PD-27

PREVALENCE OF CHRONIC DISEASE LOAD IN THE COMMUNITY

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Introduction: Most patients who are chronically ill prefer to stay home and are in dire need of accessible health care to help them cope with their illness. Recognizing that there are a large number of such patients hidden in the community, especially in the rural setting, the Pain Relief and Palliative Care Society (PRPCS), a registered charitable organization in Hyderabad, started an integrated community-based palliative care programme in the Chevella Mandal of Ranga Reddy District, Telangana state, covering a population of 55,000.

Methods: Need-assessment survey tool was administered door to door, in 30 villages, by the community organizers employed by PRPCS, to identify patients who actually need palliative care services. About 200 patients suffering from diseases like cancer, HIV, stroke, rheumatoid arthritis, psychiatric illnesses, etc. were identified. Children with cerebral palsy and muscular dystrophies, were also detected in the community. After the initial survey, all these patients were assessed clinically by physicians and those in need of palliative care service were identified. An individualized care plan is being devised for each of these patients. All patients are being regularly followed up through weekly visits by a doctor, nurse and physiotherapist. All nursing issues are addressed by the nurse. The families are empowered to handle some of the concerns through non-pharmacological measures. All patients who require physiotherapy are cared for by the physiotherapist. The community organizers regularly follow up with these patients. A few patients were provided with wheel chairs and crutches donated by PRPCS.

Results: We are able to provide continuity of care by a group of dedicated volunteers in Chevella Mandal and by a visiting team of palliative care physicians, nurses and physiotherapists who extend care beyond the hospital setting. Conducting regular meetings with the village leaders, women groups and youth volunteers helped us in creating awareness about palliative care in the community and early detection of diseases like cancer. There are many social stigmas and myths around these illnesses due to which some patients are socially isolated; some are denied access to health care; being subjected to alternative medicine and rituals. Concerted efforts are made by the team to dispel these misbeliefs and educate the community and bring about a behavioural change. The team also facilitates rehabilitative service in collaboration with the concerned government departments.

Conclusion: Since there is so much need in the community, accessible palliative care service at the primary and community health care centres, is a must to meet the needs of the patients in the community and there should be a policy initiative by the government and the NGOs to extend support through a public-private partnership.

PD-28

CARE PLAN FOR CHILDREN AT HOME, WITH LEUKAEMIA

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Introduction: MNJ Institute of Oncology & Regional Cancer Centre, (MNJIO & RCC), Hyderabad, started a dedicated paediatric palliative care programme in the year 2008. Our hospital registers 1500 new children with cancer every year and a majority of them suffer from leukemias (ALL and AML). Palliative care is provided for all children diagnosed with leukaemia, who are on curative treatment, on chemotherapy with palliative intent and also for those who are in advanced stage of disease.

Methods: The primary goal is zero-tolerance to pain and every effort is made to keep the child pain-free and comfortable. Proper care plan has been provided to the parents for management of bleeding, seizures, infection, high fever, wounds, oral care, bed sore, and bowel and bladder care. An emergency kit has also been provided to the parents, with 24x7 phone consultation facility.

Results: Children with ALL and AML on treatment or in advanced stage, are at a high risk of developing complications such as mucositis, severe pain, internal bleeding, epistaxis, bleeding gums, melena, seizures, infections, breathlessness and loss of appetite. Hence, we assess all the children in the paediatric oncology ward routinely for these symptoms and we address them early. We routinely administer oral care for all leukemic children and ensure hygiene is maintained by the staff and the care givers when handling these children. Apart from the symptom management in the ward, we empower all parents to take care of their children at home when they are discharged from the hospital. All the parents are oriented to the complications their child is likely to develop, in a simple understandable language and are prepared to handle such situations at home. They are introduced to many non-pharmacological measures to address the various symptoms. A detailed individualized care plan is provided for each child along with an emergency medical kit with detailed instructions. A regular follow-up is done through phone calls and also home visits by the paediatric palliative care staff. In case of patients with very advanced stage of disease and limited life, the end-of-life care, and the availability of hospice care is explained to the parents and they are counselled to avail these services as and when the need arises. The families are also extended bereavement care.

Conclusion: Our experience shows that integrating palliative care into the paediatric oncology program, addressing the symptoms and the likely complications at a very early stage and making the parents active partners in their child's care have increased the adherence to the treatment, improved cure rates and chances of survival.

PD-29

EFFECTIVE SYMPTOM RELIEF IN COMMUNITY USING SUBCUTANEOUS INFUSION USING INFUSER PUMPS IN INDIA

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Background: Subcutaneous infusion devices are commonly used for symptom management in palliative care to treat pain and other distressing symptoms when other routes are inappropriate or ineffective. The conventional devices are syringe drivers that deliver medications at a controlled rate, providing symptom control via continuous subcutaneous infusion of drugs. Poorly controlled symptoms result in prolonged hospitalization which increases the social and financial burden to the patient and family. Subcutaneous infusion devices have traditionally been used to deliver medications over a 24-hour period to reduce the risk of errors in setting up the syringe pump. Microbiological stability and physical and chemical compatibility data most commonly relate to a 24 hour period and it is for this reason that a 24-hour infusion period is still recommended.

Methods: Elastomeric pumps (Baxter) have traditionally been used to deliver chemotherapy and antibiotics to patients at home via intravenous route. We are reporting the use of similar pumps for symptom management as well as for end-of-life care, reducing the hospitalizations and enabling the family to care for the patient at home. It is a series of 11 cases with different diagnosis resulting in early discharge with better symptom control.

Results: A 7-day Baxter pump was used for 4 patients with recurrent malignant bowel obstruction, which was delivered through the subcutaneous route. Starting the pump significantly reduced the length of hospital stay and readmissions. Five patients with terminal agitation had a better quality of symptom control and a "good death" in presence of family members at their preferred place of care. One patient with severe bone pain due to radiotherapy flare-up had better symptom control at home while being reviewed daily in OPD for radiotherapy. For another patient, it was started in hospital for increased mobility as opposed to an infusion pump. In the later stages of his illness, the same method was used at home to provide high doses of midazolam as respite sedation at night, due to high anxiety levels and cross tolerance to benzodiazepines because of a not-so-distant history of alcohol excess.

Conclusion: Easily accessible elastomeric pumps, which are more cost effective as compared to conventional syringe drivers and infusion pumps, can be used for a wider range of symptoms empowering patients and families to choose their place of care. Though microbiological and chemical stability are less important in end-of-life care situations, more research is needed to ensure safety and increased usage.

Key words: Bowel obstruction, Community, Palliative, Subcutaneous, Symptoms

PD-30

PALLIATIVE MANAGEMENT OF ADVANCED GASTRIC CARCINOMA WITH GASTRIC OUTLET OBSTRUCTION AND POOR CARDIO-RESPIRATORY STATUS: A CASE REPORT

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Majority of patients with gastric carcinoma are diagnosed in advanced stages. When full recovery of patient is not possible, prioritizing decreasing pain and improving quality of life is a better option rather than subjecting the patient to major surgery and its risks. We intend to discuss results of palliative management of case of advanced gastric carcinoma with gastric outlet obstruction with distant metastasis. A 60-yr old female with advanced gastric carcinoma with gastric outlet obstruction and multiple metastatic lesions in lungs. Patient had history of weight loss due to inability to eat. Surgical resection of the tumour was not possible due to significant spread of tumour (distant metastasis) and the patient being poor candidate for general anaesthesia (poor cardio-respiratory status with pulmonary function tests suggesting severe restriction of large airways). So, after discussions with the surgical team, we planned to do palliative feeding jejunostomy under bilateral Transverse Abdominis Plane (TAP) block. Procedure was uneventful. Palliative feeding jejunostomy ensured adequate enteral nutritional support, thereby providing faster post-operative recovery and better quality of life. This averted possible risks associated with general anaesthesia and major surgery. Pain was managed using opioids. Respiratory physiotherapy exercises where given to patient. Significant improvement in patient's condition was seen from day one. The overall post-operative course of patient also posed a challenge to the multidisciplinary team of our institute. The further plan for the patient is to undergo palliative chemotherapy after discharge from hospital. Palliative feeding jejunostomy under bilateral TAP block appears to be a safer plan of management than subjecting the patient to major resection surgery under general anaesthesia in patients with advanced gastric carcinoma with poor cardio-respiratory status.

Key words: Gastric carcinoma, Gastric outlet obstruction, Palliative management, Poor cardio-respiratory status

PD-31

THE ROLE OF MHEALTH IN NON-COMMUNICABLE DISEASES CARE COORDINATION: DESIGNING WITH PATIENTS AND CAREGIVERS

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Background: Low- and middle-income countries (LMICs) now bear the majority share of the burden of non-communicable diseases (NCDs) such as cancer (WHO), yet their health systems are inadequately prepared (Farmer, et al). At the same time, there are over 6 billion mobile phone subscribers worldwide and at least 50% of the population in LMICs owns a cell-phone (PEW). The field of "mHealth" seeks to capitalize on this opportunity to strengthen linkages between patients, caregivers and healthcare personnel with the ultimate goal of improved health outcomes. MHealth is already being used to improve access, adherence, and quality of care in many LMICs for infectious diseases such as malaria and HIV/AIDS (Tomlinson). There is an opportunity to apply these mHealth tools and lessons to NCDs such as cancer, however the needs of end users, including patients, community health workers and caregivers, must be well understood if we are to successfully roll out impactful mHealth interventions. Tools are available now to help us in the fight against NCDs; we need to know how to apply them effectively, integrate with health systems and community networks, and solve real challenges experienced by patients, families, clinicians, and administrators alike.

Methods: This presentation will provide an overview of the mHealth landscape, and examples of evidence-based use cases to support prevention and screening, diagnosis and treatment, and palliative care for NCDs such as cancer. It will also highlight the importance of human-centred design (HCD) in mHealth interventions for NCDs.

Results: Attendees will have a basic working knowledge of HCD and how to apply it to mHealth designs and use cases in their own contexts. They will be able to map out stakeholders and user requirements, creating a blueprint for their own mHealth programmes.

Key words: Community health workers, Human-centred design, mHealth, Non-communicable diseases, Technology

PD-32

EARLY SUSTAINED COMPREHENSIVE PHYSIOTHERAPY IS AN INTEGRAL COMPONENT OF ANTI-CANCER CARE AND ENSURES SUCCESSFUL OUTCOME IN ADVANCED CURABLE CANCERS: A CASE REPORT

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Patients with potentially curable cancers often present with advanced disease. In addition to general debility, pain and tumour-related wasting, patients with advanced cancers also experience complications from the mass effect of tumour. In case of abdominal tumours, this mass effect results in respiratory compromise, limitation of mobility and lower limb oedema from venous compression. To mitigate these effects and ensure successful outcomes, supportive care including early intensive physical therapy is required, in parallel with anti-cancer treatment. Here we report the outcome of such integrated intervention in a patient with advanced ovarian germ cell tumour (GCT) treated at the Tata Medical Centre, Kolkata. A 12-year-old girl was hospitalised for management of ovarian GCT complicated by malignant ascites. At presentation, she was bedbound with anasarca, abdominal pain and dyspnoea. The ECOG performance score was 4. Breath sounds were decreased in both lower lung fields. Muscle strength was Grade 3-minus in all four limbs. Bilateral lower limb oedema was complicated by lymphorrhoea and left proximal deep vein thrombosis. In addition to cytotoxic therapy, treatment included nutritional support, pain control, anticoagulation and intensive physiotherapy. Respiratory therapy included a programme of periodic deep breathing exercises, incentive spirometry, chest vibration and positioning to the right lower zone. Limb physiotherapy included active upper and lower limb exercises as well as bandaging and elevation of the lower limbs. By Day 10 of hospitalisation, she could stand with support and over time, was able to ambulate with a walker. Physical therapy was continued through two major abdominal surgeries, ensuring early post-operative recovery of mobility. She successfully completed all therapies three months ago. Early referral to physiotherapy services and an intensive programme of physical rehabilitation optimises recovery, decreases treatment-related complications and contributes to successful outcomes in patients with advanced, potentially curable cancers.

Key words: Cancer, Physiotherapy

PD-33

IMPORTANCE OF PROPER EVALUATION AND TREATMENT USING THE PRINCIPLES OF PALLIATIVE CARE

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Introduction: In recent times, palliative care has evolved as a separate medical specialty. Palliative care is holistic care, involving pain management and relief from other symptoms, providing emotional relief to both patients and the family. All that is correctable should be corrected at the right time rather than taking it for granted that the patient is already in terminal stage of disease and the condition is irreversible.

Objectives: To assess how involving the principle of palliative care using "EMMA", we could correctly evaluate and manage every symptom of patient at the right time so that we can improve the quality of life of both the patient and the family. To involve the paramedical staff and other palliative team members in assessing the symptoms of the patient by constant training at different levels and to provide a holistic approach to management of symptoms in order to improve the quality of life of patients and bring confidence to care givers both professional and non-professional.

Methods: RMD Pain and Palliative Care Centre has two hospices and hospitals and home-based care. Using the "EMMA" principle we could correct the correctable at the right time, thereby providing patients improvement in symptoms by early detection of problems and emotional relief to family. We see in a month an average of 5-10 patients in whom a lot of factors like hyponatremia, hypokalaemia, hypoglycaemia, metabolic acidosis, anaemia and super added infection, if corrected at the correct time can improve the quality of life.

Case 1: A 83-year old male with end-stage multiple myeloma was admitted with pain. In addition to severe back pain for which he was adequately managed, he also complained of headache, nausea and showed signs of increased irritability and restlessness, like delirium. When the patient was evaluated he was found to have low sodium level of 120 meq/L. Once his hyponatremia was corrected, his symptoms improved and quality of life was very much improved and he could do his activities of daily living.

Case 2: 64-year old male with ca. gallbladder mets and liver failure suddenly became more lethargic, weak, confused and complained of constipation and tremors. When he was evaluated, he had low potassium level of 2.1 meq/L, low-grade fever and viral encephalitis. We corrected the potassium level and treated him with antivirals. His symptoms improved and he was discharged.

Case 3: 80-year old female patient, bedridden due to cerebrovascular disease and who had her bladder catheterized for a longer duration of time, had sudden episode of fever associated with delirium for 2 days. When evaluated, she was found to have severe urinary infection and malaria. When treated with antibiotics, her symptoms improved to a great extent.

Conclusion: Proper evaluation and proper treatment to correct the correctable at the right time will reduce the burden of both the patient and the family members. This will in turn change the thinking process of many medical professionals who think palliative care is only for pain management and end-of-life care support. Every symptom should not be attributed to the advanced stage of disease and left as something that cannot be treated. Every palliative care team member should be educated to assess and review each symptom and manage it effectively.

PD-34

ROLE OF PALLIATIVE CARE IN IMPROVING QUALITY OF LIFE AMONG PATIENTS OF ADVANCED CANCER

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Background: The current training in oncology seems inadequate in terms of providing palliative and comprehensive care to advanced cancer patients, as the focus is mainly on curative and disease-modifying treatment. The focus in such patients should be on symptom control and improving their quality of life instead of life prolongation, at any cost. This study was aimed at assessing the role of palliative care in improving the quality of life of patients with advanced cancer.

Methods: This study was designed as a cross sectional survey. Unit of study were cancer patients referred to palliative care service. The approval from Ethics Committee of PGIMER was taken for the study. Patients were assessed on first day of referral to palliative care clinic and after 7-10 days of care under palliative care using the Edmonton symptom assessment system (ESAS) for symptom burden and the Functional Assessment of Cancer Therapy-General (FACT-G) questionnaire for quality of life (QOL).

Result: Pain was the commonest and the highest on symptom scale. The total score for QOL was low due to high symptom burden. After palliative care intervention there was a marked improvement in the mean pain score. The other symptoms also showed improvement and this led to marked decrease in the mean distress score. The total score for QOL also showed significant improvement with maximum improvement in the physical wellbeing domain.

Conclusion: Palliative care intervention is very important to relieve symptoms and to improve the QOL of advanced cancer patients so that they can live comfortably for their remaining days. Patients admitted to the hospice showed the most improvement as they could be assessed regularly and treated accordingly.

PD-35

A MODEL OF EARLY INTEGRATION OF PALLIATIVE CARE SERVICES FOR CANCER PATIENTS AT A HOSPICE IN UTTARAKHAND

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Introduction: The concept of integration of palliative care services with outpatient cancer clinics is considered a way of early integration of palliative care for cancer patients. This model offers continued palliative care support throughout the cancer trajectory. Scientific evidence reports that patient outcome improves by early integration of outpatient cancer clinics and specialized palliative care services but still such integration is lacking. Ganga Prem Hospice aims to offer early palliative care services to its patients.

Methods: Every month, Ganga Prem Hospice organizes free oncology OP consultations in Rishikesh, Uttarakhand. Every month 100 to 120 patients visit the OP out of which 40 to 50 are cancer patients, 3 to 4 are suspected cancer patients (SCA) and 7 to 10 are terminally ill cancer patients (TICP). Suspected cancer patients, terminal cancer patients and any cancer patient wishing to discuss their problems met the palliative care doctor at the monthly OPD. Data from May to August 2015 was tabulated to assess details of additional support services offered by palliative care doctors at Ganga Prem Hospice, Rishikesh.

1. Explaining the challenges patients could come across while undergoing cancer treatment and how to deal with those.
2. Explaining to them about government funds available for cancer patients and funding organizations that offer support to cancer patients.
3. Assisting oncologists to break the bad news of the diagnosis.
4. Discussing and talking about the fears of the patient and their families in the early phase of their disease.
5. Guiding and supporting them at the cancer hospitals for treatment.
6. Offering home care to patients who develop treatment-induced side effects, e.g. radiation-induced ulcers and chemotherapy-induced paraesthesia and numbness.
7. Understanding the psychological and social issues in home care of patients in early stages of cancer and helping them deal with it.
8. Follow up of patients with early diagnosis of cancer and explaining to them the difficulties that could arise if they did not adhere to the treatment.
9. Monitoring adherence to treatment.
10. Dealing with anxiety of patients and families at each step of their treatment.

Results: Number of patients offered support by palliative care doctor at the clinic from May to August 2015: 49. Patients helped by guiding them at cancer hospital by accompanying them to their oncology OPD: 10. Helped by financial assistance: 16. New home care patients: 14. Those given details of health schemes by the government: 8. Patients who could not be covered by the home care team on account of the distance and were offered helpline services: 8.

Conclusion: Life-limiting disease imposes tremendous stress on the patient and support is needed in early disease too. Palliative care doctors can assist treating physicians in offering this much-needed support in the early phase of any life-limiting disease.

PD-36

RESOLVING CONSTIPATION AS PALLIATIVE

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Constipation among patients, particularly those on opioids, is widely prevalent. When they are unable to have a bowel movement in 3 or 4 (or more) days whether because of or in spite of drugs, discomfort, helplessness, dependency, embarrassment, dejection is all commonly experienced by the patient. In this context, an approach that enables self-management of constipation, independent of medical assistance, is palliative in itself. Here two remedial measures that can be practiced independently of medical expertise are suggested.

1. An edible plant *Euphorbia heterophylla*, commonly known as Mexican fire (English), Jalabedhi (Kannada) or Palperukki (Tamil) has laxative properties. It is a weed, resistant to herbicides. Agricultural scientists deal with it as a menace. The leaves can be cooked and eaten. Alternatively, the leaves are ground to a paste and preserved. One or two spoonsful, when taken in a glassful of water brings about a relieving bowel movement in two hours. The leaves are odourless and tasteless, hence easy to consume. This plant grows wildly and widely.
2. Yet another tool to get relief from constipation is to take water enema. Self-administration can be taught with an illustrated chart. Enema is an ancient colon cleansing technique practised in several civilizations and various medical practices. Water enema is harmless, effective, inexpensive and brings immediate relief. Allowing the patient to independently deal with bowel problems, can empower, improve well-being and better the quality of life for the patient.

PD-37

TRAINING ISSUES IN HOME-BASED PALLIATIVE CARE

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The number of people with a serious life-threatening illness continues to grow as a result of the aging population and advances in technology that allows increased longevity. Palliative care is a dynamic field with multifaceted approach that has to match the evolving needs of the patient and family. It focuses on quality of life, control of pain and other distressing symptoms, and attention to the psychosocial, emotional and spiritual needs of the patient. However, this component of health care, which is specialized has been sidelined for a long period. Hence, specially in our scenario, there are many shortcomings in home-based palliative care. Therefore, there is an urgent requirement to standardize the palliative care services provided at home and establish training modules to implement these standards levels of care.

PD-38

NURSING CARE IN HOME-BOUND PATIENTS OF GUJARAT CANCER AND RESEARCH INSTITUTE HOME CARE SERVICES

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Background: Terminally ill cancer patients may not be able to attend hospital and may require home-based care. But there are many challenges for caregivers like their own health, insufficient skill to manage patient symptoms, limited time and family circumstances.

Aim: This retrospective study is conducted to describe the role of trained staff nurse in home care of terminally ill cancer patients.

Methods and Results: Study period was January to December 2014. Information was collected from the diary of the nurse, who regularly visited patients for home care. Total 131 patients were provided home care and number of visits ranged from 3 to 4 times for every patient, every fifteen days. Their symptoms were pain (91 patients), nausea or vomiting (10), breathlessness (9), constipation (21), diarrhoea (10), bedsore (17), fungating wound (43), fear (11), worry (11), depression (23), anxiety (27) and spiritual issues (81). For physical symptoms medications were prescribed by palliative care physician but 80% of patients' spiritual and psychological symptoms were relieved by communication, counselling and support by nurse.

Conclusion: Nurse has played very important role by counselling patient and caregivers and education of caretaker in management of wound, bedsore, stoma care and regarding nutrition.

Key words: Cancer patients, Home care, Nurse role

PD-39

DEPRESSION, ANXIETY AND QUALITY OF LIFE IN HEAD AND NECK CANCER PATIENTS BEFORE AND AFTER RADIOTHERAPY

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Background: Radiotherapy is the backbone of most head and neck cancer treatment. Along with surgery and chemotherapy, several known adverse effects may cause significant depression and anxiety in the patients, and thus a reduction in quality of life.

Objective: To assess symptoms of depression and anxiety and quality of life before and after radiotherapy in patients with head and neck cancer.

Methods: Prospective observational study of 100 head and neck cancer patients undergoing radiotherapy at a tertiary centre over 24 months was conducted. Depression and anxiety scores were assessed using the Hospital Anxiety and Depression Scale (HADS), and quality of life with Functional Assessment of Cancer TherapyHead and Neck (FACT-H&N) scale. HADS and FACT H&N were completed at two time points before and after completion of radiotherapy.

Results: Mean depression and anxiety scores increased and quality of life scores decreased from before to after radiotherapy. Prevalence of depression increased from 24% pre-treatment to an addition of 35.5% of subjects after radiotherapy. As the depression symptom score increases before and after radiotherapy the FACT H&N score decreases.

Conclusions: Findings suggest that rates of depression in head and neck cancer patients increase after treatment, with an addition of a third of subjects experiencing clinically significant symptoms of depression after radiotherapy. There is a significant decrease in the quality of life after the treatment.

Key words: Anxiety, Depression, Head and neck cancers, Quality of life, Radiotherapy

PD-40

THE INTERDISCIPLINARY TEAM'S PERCEPTION OF PRIORITIES IN PALLIATIVE CARE: A FREELISTING

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The needs of a terminally ill patient are multidimensional and vary during the course of his illness. It is difficult for a single professional to cater to all the needs of the patient throughout the illness. A palliative care team could take holistic care of the patients and their families from the beginning to the end. This team consists of doctors, nurses, social workers, pharmacists, volunteers, physiotherapist, nutritionist and non-clinical staff. In fact, the patient's family and the patient himself also contribute to the caring team. This study aimed at exploring how the different professionals prioritize their tasks in patient care. The qualitative method of freelisting, was used with 14 professionals from the above-mentioned interdisciplinary team, in Pune, India. The responses were analysed for frequency and rank. This study brought out how they were diverse in their approaches, but united under the sole mission of excelling in patient care.

Key words: Interdisciplinary team, Palliative care, Perception, Priority

PD-41

USE OF WHO ANALGESIC LADDER FOR CANCER PAIN MANAGEMENT IN A TERTIARY CANCER CENTRE IN NORTH-EAST INDIA

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Aim: The aim of this retrospective study is to determine which step of WHO analgesic ladder is most effective in managing the physical aspect of cancer pain.

Methods: WHO analgesic ladder is universally accepted for cancer pain management. Altogether 650 patients have been studied in the tertiary cancer centre. It is a single-centre retrospective study. All type of cancer patients in all age groups irrespective of sex has been included in the study. Each patient has been followed up, up to 3 visits for pain control study. The patient's pain has been assessed for mild, moderate and severe types: 55 (8.5%) with mild pain; 195 (30%) with moderate pain; 400 (61.6%) with severe pain.

Results: Altogether 55 of patients were started with Step 1 medications for mild pain on first visit, 195 patients on Step 2 for moderate pain and 400 patients on step 3 medications. Those started with Step 1 medications on first visit did not get adequate pain relief and again started with Step 2 medications. Of those who started with Step 1 medications, 80% got complete pain relief. The remaining 20% had to be started with Step 3 medicines. On Step 3, 90% got adequate pain relief and the rest had to be given psychological counselling with further evaluation. On the third visit, from among those who had been upgraded from Step 1 medicines to Step 2, 80% got pain relief whereas 20% needed to be upgraded to Step 3. Among the Step 3 users upgraded from Step 2, 89% got adequate pain relief and the rest 11% needed further evaluation.Altogether 3.8% (25 patients) got adequate pain relief with Step 1 medications. 27.6% (180 patients) got adequate pain relief with Step 2 medications. 61.7% (401 patients) got adequate pain control with Step 3 medications.

Conclusion: It is seen from the study that Step 3 medicines of the WHO Cancer Pain Ladder are best suited for cancer pain management.

PD-42

PSYCHOLOGICAL DISTRESS IN PREOPERATIVE SURGICAL PATIENTS AND RELATIONSHIP WITH ANXIETY: AN OBSERVATIONAL STUDY

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Objectives: To find out incidence of psychological distress in pre-operative surgical patients and its relationship with anxiety in such patients.

Background: Psychological distress is a common finding in cancer patients. Distress thermometer (DT) is a validated and popular tool for measurement of distress in such patients. Hospital Anxiety and Depression Scale (HADS) reading, which records anxiety and depression in hospital patients, was found to be in concordance with the DT. Surgical patients, in their pre-operative period do suffer from anxiety. However, presence of distress in such patients is a grey area and needs evaluation. The present study aims to detect distress in pre-operative surgical patients and if detected, the incidence, severity and relationship of anxiety in such patients.

Methods: This was an observational study enrolling patients from general surgery, ENT, and obstetrics and gynaecology departments in the patients who are posted for planned surgery over a period of three months in a tertiary care setup in West Bengal. Written informed consent was signed by each participant before enrolment in the study. All the patients were interviewed within 30 to 60 minutes before surgery with the distress thermometer and Hamilton's Anxiety rating scale (HAM-A). Evidence of distress and anxiety was thereby quantified and relationship was searched. Pre-operative use of anxiolytic drugs was also noted and the effect of such drugs in anxiety and distress, if any was also noted.

Results: Out of total 48 enrolled patients, 28 were female and 20 males. Most of them received some benzodiazepine anxiolytic in the preoperative period. Diazepam and lorazepam were most commonly used anxiolytic (33% and 29% respectively). Distress and anxiety were noted in both groups of patients. There was a positive correlation between these two parameters in bivariate analysis (Pearson's Correlation coefficient, r value 0.76) and it was statistically significant ($p<0.001$).

Conclusion: Pre-operative patients, irrespective of gender and educational status, do suffer from psychological distress like cancer patients. Distress was positively correlated with anxiety in such patients. DT evolved as a useful tool for identification and quantification of distress in non-cancer patients.

Key words: Anxiety, Anxiety rating scale, Distress, Distress thermometer, Hamilton's, Pre-operative, Surgical

PD-43

DEVELOPING NURSE LEADERSHIP TO EMPOWER INTEGRATED PALLIATIVE CARE THROUGH A LINK NURSE PROGRAMME

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Background: The World Health Assembly has urged the integration of palliative care (PC) into health systems as a means of increasing access to care for people with chronic incurable diseases. Nurses have a crucial role in delivering health care. Empowering nurses in core clinical areas to deliver PC through a link programme is an effective model utilized in Uganda, India and several other countries. Building effective leadership skills amongst specialist nurses is crucial to continued integration. We report a novel nurse leadership initiative, which is supporting extension of the nurse link model.

Methods: 19 nurses and 1 clinical officer trained in palliative care to minimum Diploma level have begun a 2-year Fellowship training in leadership. As part of this project, 6 nurse leaders developed a project to use a link nurse model to integrate PC into 2 urban and 3 rural district hospitals. Project steps included advocacy to ensure management support, identification of 90 nurses to be trained in basic PC using an agreed training package (includes Ugandan protocols and the PC Toolkit), an initial 5 days training followed by clinical modelling, mentorship and supervision for each hospital. A log book was used by each trainee for self-evaluation and reflective practice. 31 nurse leaders from MPCU are directing this project.

Results: All completed training showed immediate knowledge gain (pre- and post-training assessments). Trained link nurses have been able to integrate PC in their setting and demonstrated documented PC interventions. Oral morphine has been accessed for the first time in 2 hospitals. Nurse leaders have been able to advocate and initiate training in novel settings and grow their own leadership skills.

Conclusion: Nurse leadership development is an essential component of empowering generalist nurses and acts as a catalyst for change in and beyond their own workplace. Effective nurse leadership within a multi-disciplinary approach is key to sustainable, integrated PC within health systems. This model of nurse empowerment that supports values-based change within the health system is an effective way to increase access to PC.

Key words: Link nurse, Nurse leadership, Palliative care

PD-44

EXPLORING THE FACTORS THAT MOTIVATE MAKERERE MULAGO PALLIATIVE CARE UNIT VOLUNTEERS AND THEIR EXPERIENCES AS THEY CARRY OUT THIS ROLE

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Background: Sub-Saharan Africa and Southern Asia has the most countries with increasing incidence of cancer and chronic illness. Unsurprisingly, the demand for palliative care services in these settings is also increasing. Volunteers play an important role in direct patient care for patients with palliative are needs. However, their motivations to provide these services are poorly understood. The Makerere Palliative Care Unit (MPCU) recruited and trained 15 volunteers, and integrated them in palliative care service provision. In 2012-2014, they offered services to 727 patients and made 3052 patient contacts. Their contribution has included practical physical care, psychosocial and pastoral support to patients and their families.

Aim: To explore the factors motivating MPCU volunteers and their experiences while carrying out this role.

Objectives: To understand what motivates palliative care volunteers working in Mulago Hospital. To explore the experience of palliative care volunteers as they carry out their role.

Methods: A qualitative exploratory study using semi-structured interviews was used with the 12 MPCU volunteers to collect data.

Results: Teamwork, career development, acquiring new skills, compassionate/humanitarian contribution, training, and mentorship were identified as themes that motivated volunteers. On the other hand, volunteers also identified a number of challenges within their work that included level of high expectation from patients and families, as well as lack of mutual respect.

Conclusion: The contribution of volunteers is unique in the palliative care setting and can result in the volunteer being the most significant person to the dying person. However, for them to perform their role well there should be improved relations with all colleagues involved in the patient care, as well as income generating activities to sustain this valuable service to patients. Many of the volunteers have used this experience to move on to other roles in their communities.

PD-45

A CLINICAL STUDY ASSESSING THE POINT PREVALENCE OF PALLIATIVE CARE NEEDS OF PATIENTS IN GYNAECOLOGICAL ONCOLOGY WARD AND WOMEN'S HOSTEL, MULAGO HOSPITAL, KAMPALA

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Background: Assessing the need for palliative care (PC) is an essential component in ensuring adequate models of service provision and integration. Gynaecological malignancy is common in low- and middle-income countries. An integrated model was developed with the gynaeco-oncology unit involving training, link nurses, holistic support, symptom control guidelines, patient pathways and a review of palliative care needs.

Methods: All adult in-patients in the gynaeco-oncology ward and women's radiotherapy hostel were asked to participate. An assessment tool that included the APCA African POS, POS S, WHO performance status and demographic information was administered by structured interview.

Results: 57 patients were eligible and all had cancer. 54 recruited and 52 completed. Oncology ward 25(46.3%), hostel 29(53.7%). 41 (64.6%) between 40 and 59 years 22(48.9%) income less than 1 USD per day. Performance status 1: 10(19.2%), 2: 22(42.3%), 3: 11(21.2%) and 4: 6(11.5%). Cancer prevalence cervix 38(73.1%); breast 4(7.7%); ovary 6(11.5%); endometrial 3(5.8%). 27(50.9%) had no access to palliative care but 19(36.5%) prescribed oral morphine. 53 participants (98.1%) completed the APCA POS with a mean score of 14.74. Domains of physical and psychological wellbeing mean 6.2, interpersonal wellbeing mean 4.7, existential wellbeing mean 3.6. 52 participants the POS-S Scale. 50(96.2%) had one or more symptoms; 15/52 (30.0%) 1-2 symptoms; 10/52 (20.0%) 3-4 symptoms; 13 (26.0%) 5-6 symptoms; 10/52 (20.0%) 7-8 symptoms and 2/52 (4.0%) had 9 symptoms. Pain was most prevalent 28(52.8%), 26 (49.1%).

Conclusion: Unmet PC needs are significant even with many having access to PC interventions. This patient population is also affected by poverty and social needs. Training of all the health care providers is needed alongside holistic support for patients and families. Clear referral pathways must be present within and outside the hospital. Oncology units have an important role in delivering PC interventions in level 1 and 2 (WHA resolution) and need support for more complex level 3 interventions from specialist services.

Key words: Gynaecology, Needs assessment, Palliative care

PD 46

HOLISTIC MANAGEMENT OF METASTATIC MUCINOUS CYSTADENOCARCINOMA OF THE APPENDIX WITH PSEUDOMYXOMA PERITONEII WITH MODERATE ASCITES WITH INCISIONAL HERNIA WITH MUCOCUTANEOUS FISTULA

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Background: 45-year old female, P3L3 with metastatic mucinous cystadenocarcinoma of the appendix presented with complaints of increasing pain and abdominal distension along with radiological evidence of extensive peritoneal left pleural and pericardial deposits following which she underwent therapeutic paracentesis with removal of 800 ml of ascetic fluid containing malignant cells. Presented with complaints of generalised abdominal distension subacute in onset progressive in nature associated with history of breathlessness at rest with early satiety, and wound over the anterior abdominal wall since the past 2 days along with leakage of yellowish fluid from the wound. On examination, pallor, ECOG 3, decreased air entry in the left mammary region, diffuse abdominal tenderness, scar of previous surgery, generalised abdominal distension along with swelling measuring 5*4 cm in the hypogastric region with overlying wound measuring 2*2 cm with yellowish fluid trickling from its mouth were noted. Was managed with a stoma wound management system along with symptomatic pharmacological treatment for pain and ascites. A comprehensive management plan was formulated. Counselling about the prognosis was initiated with family members with the purpose of identifying and managing collusion. Discussion regarding continuity of care with emphasis on telephonic liaison, scheduled home care visit and hospice admission was initiated with a plan to introduce advanced care directives at a later date.

Discussion: A holistic treatment plan considering the family as a functional unit of treatment with the individual patient at the apex forms the very basis on which the edifice of supportive management is to be built. Communication and best possible utilisation of the available resources are the two pillars which can embolden the physician to make decisions crucial to patient wellbeing.

PD-47

RAINBOW OF PALLIATIVE CARE ACTIVITIES CARRIED OUT THROUGH A PRIMARY HEALTH CENTRE

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Background: This primary health centre caters to a population of 32000. With around 100 symptomatic cancer patients, it has always been my passion to focus on the quality of life of these patients and have been stirred emotionally to contribute my might and influence through social activities that help in the different facets of health care delivery.

Methods: We as a team of dedicated workers including ASHA workers, volunteers, junior public health nurses, palliative care nurses, medical officer and local body workers decided to have a seamless relationship towards achieving set goals.

Activities: Following several rounds of talks with the local MLA, we managed to acquire an ambulance for domiciliary care (supply of medicines, wound care, giving IV fluids, procedures, etc.). A joint bank account named Karunyam was started exclusively for day-to-day palliative care expenses. We started a community-based geriatric care (CGBC) as a public-private partnership, with the Head of the Department of Community Medicine, Gokulam Medical College. We have a database of geriatric patients who are cared for by ASHA workers, who have been given glucometers, BP apparatus and glucometer strips to monitor health indices. Several patients are given free food twice weekly. The local Rotary Club has provided free-of-cost uniforms to the ASHA workers. Micro-donations collected through 100 boxes kept in the local government (panchayat) office, the community also contributed and got involved in the project. As a recognition of the services we could provide, on behalf of the whole team, I accepted the "Excellence Award for Public Service" in 2014.

Conclusion: We have more ambitious projects in mind and hope to get these realized in a phased manner.