POSTER PAPERS

HEAL YOURSELF

Bibhuti Mishra
E-mail: healyourpain@yahoo.co.in

Introduction: Let us analyze the cause of pain. Every part of our body needs tender care like a child. If it is neglected, it gives a complaint in the form of pain. Pain out of pain is a part of causing pain also adds to, so the solution lies in attending to the body organs through mind-body relationship. Healing is through generating awareness on the organ by certain practices like Reiki, Yoga Nidra, and other relaxation techniques. Energy from food is spent in physical and mental work. An experiment showed that changing thought process consumes more energy than while fixed at one point.

Observation: So awareness on organ by rotation through recorded voice consumes much less energy. Thereby total energy is conserved. It leads to increase in body vibration. This helps in relaxation of muscles and relief of the pain. It not only helps in relieving physical pain, but also the pain manifested due to emotions. Relief of Cancer pain has been reported with the patients of Acharya Harihar Regional Cancer Research Centre, Cuttack, India. The reduction in morphine intake was also observed. Healing a group of people at a time and also healing from a distance have been found to be successful.

Conclusions: Our god-gifted body has the capacity to heal itself physically as well as mentally. Only it needs to be channelized properly.

DIFFICULTIES IN PROVIDING PALLIATIVE CARE IN RURAL INDIA (WEST BENGAL) - EXPERIENCE OF AN NGO

Aditya Manna, Shyamal Kumar Sarkar
E-mail: adityamanna101@yahoo.co.in

Introduction: As in any developing countries, state of West Bengal in India has a huge burden of cancer patients in advanced stage coming from rural area where awareness regarding the usefulness of palliative care in rather poor.

Objective: Our goal is to give a pain-free, good quality of life in these advanced stage cancer patients. Objective of this study is to identify the main difficulties in achieving the above goal in a rural village setting in India.

Methods: Advanced cancer patients in need of palliative care in various villages in of rural India were selected for this study. Their symptoms and managements in that rural surroundings were evaluated by a nongovernmental organization (NGO; under the guidance of a senior palliative care specialist) working in that area. An attempt was made to identify the main obstacles in getting proper palliative care in a rural setting.

Results: Pain and fatigue are the main symptoms affecting these patients. In most patients, pain and other symptoms control were grossly inadequate due to lack of properly trained manpower in the rural India. However, regular homecare visits by a group of social workers were of immense help in the last few months of life. NGO team was well-guided by a palliative care specialist.

Conclusion: There is a wide gap of trained manpower in this field in rural areas of India. Dedicated groups from rural area itself need encouragement and proper training, so that difficult symptoms can be managed locally along with necessary social and psychological support to these patients.

ANGER MANAGEMENT IN CANCER PATIENTS IN PALLIATIVE CARE

Palika
E-mail: ravindermohan@cansupport.org

Introduction: Anger is a strong emotion. It does not stay static but is constantly changing. It may build up to a crescendo, when it reaches to a peak and it slowly dissipates. It is usually expressed verbally or physically. People who are touched with cancer also sometimes experience anger.

Objective: The aim of this study is to find out the reasons/causes for anger in cancer patients. When the cause for anger was identified and dealt with they are at peace.

Method: The method used was that the counselor listened and helped the patient to identify the cause for anger. Usually the causes for anger that were identified were unfocussed anger, for example, angry with God or with the medical professionals; anger due to insecurity, for example, financial problems, marriage of daughters, etc.; anger due to the disease and unmet needs; and some had anger due to pain, disability, and other effects of illness.

Result: When the counselor listened to their anger, the anger came down. There was a huge change in their behavior.

Conclusion: When timely intervention is done and the angry episodes are dealt with, anger comes down. The patient and the family members are at peace, even the team members feel much better.

WHAT ARE THE CAUSES OF STRESS AMONG PALLIATIVE CARE NURSES?

Savita Luka Masih
E-mail: ravindermohan@cansupport.org

Objective: To study the causes of stress and its management in palliative care nurses at Cansupport.

Introduction: Working in palliative care can be very satisfying, but it is also quite stressful. This is especially for palliative care nurses who work closely with patients at the end-of-life. Stress may build up and cause burnout. Therefore, it is important to measure stress, find out its causes, and institute remedial measures.

Method: A research questionnaire for nurses was designed to find the causes of stress. The study was conducted on 17 palliative care nurses who were asked to fill a questionnaire listing causes of stress and any symptoms and signs of stress from which the nurses suffered. Then all the nurses were asked to listen to music 30 min and do active relaxation strategies for 4 weeks. After this they were again asked to fill the same questionnaire again.

Results: The pre-questionnaire showed that most of the nurses were suffering from some signs or symptoms of stress. The post-questionnaire which was filled 1 month after the prescribed activity showed that 50-60% of the nurses had reduced symptoms and signs of stress.

Conclusion: Most palliative care nurses are aware that self-care measures are important to reduce stress, but this has not translated into practice of self-care techniques. They require motivation and structure to actively take better care of themselves to reduce stress and burnout.

MANAGEMENT OF FUNGATING WOUNDS IN CANCER PATIENTS WITH HONEY DRESSINGS

Raj Shindu
E-mail: ravindermohan@cansupport.org

Introduction: Fungating wounds often foul smell, have exudates, and may bleed excessively. Because of these factors the patients face isolation and have poor self-image. Honey dressing is a novel way of taking care of these difficult problems.

Objective: The study of the efficacy of honey dressings on fungating wounds.

Method: Ten patients with fungating wounds had the wounds dressed with honey. Good quality honey is easily available in market and neem honey is available with a chemist. The caregivers were taught to do dressing with honey. The patients were followed-up for 2 weeks and wounds were examined every alternate day.

Result: Honey dressings help to take care of the major problems associated with fungating wounds like foul smell, exudates, and excessive bleeding. Both patients and caregiver were satisfied with honey dressing, as assessed by an objective checklist.

Conclusion: Honey dressings are effective in care of the problems associated with fungating wounds. This is a culturally acceptable form of wound care.

CAN THE PALLIATIVE CARE PROFESSIONALS HELP PATIENTS DIE AT THEIR PREFERRED PLACE OF DEATH?

Navdha Sharma
E-mail ravindermohan@cansupport.org

Introduction: Planning for 'preferred place of death' is an essential component of palliative care. Being aware that an illness cannot be cured, can provide patients with more choices. The desire to die at home should always be respected as far as possible. A good palliative care can help in, to ensure a good death for all patients through careful planning and listening.

Objective: The aim of this study is to find out the preferred place of death for cancer patient where home care is available.

Method: A set of questions has been asked from the caregiver during the post bereavement visit by the counselor about their 'loved ones wish' regarding their preferred place of death.

Result: A total of 165 patients were enrolled in this study. In all, 80% of the patients died at home, 16% in hospital, and 4% in hospice care. Those 16% who died in the hospital had following reasons for the same:
Symptoms could not be managed at home
Lack of acceptance of death
Patient did not know the diagnosis
Lack of preparations for end of life.

Conclusion: This study reveals that good symptom control; confident, committed, and trained palliative care practitioners; adequate nursing care and palliative care education; and awareness allows patient to choose their 'preferred place of death' with dignity in dying.

PALLIATIVE CARE FOR BEGINNERS

Neha Tripathi
E-mail: nehatripathi@canceraidsocietyindia.org

I would say it is caring for the uncared.

Palliative care should start early and not only in terminal illness.

WHO Definition: An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.

Priority Actions for the Governments: Implement programs for improving the quality of life of the majority of patients and their families.

Programs to include pain relief, other symptom control, and psychosocial and spiritual support.

Awareness that cancer pain can be avoided.

Ensure the availability of oral morphine.

Thought for Us: Even the hardcore criminals who are sentenced to death are asked for their last wish which is fulfilled and they are given painless death. It is very unfortunate that in our country the patients who get a death warrant by cancer suffering for months together in excruciating pain cursing themselves for none of the sins they have committed. Should they not be given freedom from acute pain as they pray for an early death.

OUT OF HOURS SERVICES FOR HOME-BASED PALLIATIVE CARE AT HYDERABAD

Vidya, Anuradha S, Kamalakar V, Palat G
E-mail: vidyakumarasamy@gmail.com

Introduction: Life At Your Doorstep–a home-based palliative care service for patients living within 40 km radius of Hyderabad–is delivered as part of an integrated palliative care service of a tertiary cancer hospital. It cares for 80 or more terminally ill patients registered with the program at a given time. Under the guidance of palliative care physicians, direct home care visits are on a weekday (working hours) basis; whereas, out-of-hours (OOH) service is provided through phone consultations, 7 days a week.

Objectives: To evaluate the quality of OOH service and its ability to meet patient expectations.

Methods: Data collection on details of phone-based consultation for a period of 3 months. Feedback questionnaire forms filled by staff of home care team and patient or caregiver.

Result: Preliminary results indicate 60% of the phone calls are made between 9 pm and 12 pm. Nearly all phone calls have been attended by counselors and 70% of the calls made were regarding end of life care and 40% nursing issues. Ninety percent of the patients passed away at home. Feedback questionnaire on a Likert scale rated that the patients and caregivers were satisfied with the care provided by the home care team.

Conclusion: Our study gives an insight into the service provided and what was expected from a patient/caregiver perspective. In India, service provision for OOH is not standardized.

Our study identified the crucial domains for improvement as professional education, online documentation, and confidential sharing of data between services to ensure continuity of care and support.

QUALITY OF LIFE IN FAMILY CAREGIVERS OF PATIENTS WITH TERMINAL CANCER: A CROSS-SECTIONAL STUDY

Malathi G Nayak, Anice George, Vidyasagar MS
E-mail: malathinayak@yahoo.co.in

Cancer is a major public health problem of the world. It affects many people directly or indirectly. Cancer can worsen the caregiver's health, impair social life, increase stress, and cause depression. Diagnosis of cancer has a significant impact not only on patient, but also on their family caregivers. Therefore, cancer has a substantial impact on both patients and families.

The purpose of the study is to explore the quality of life of caregivers of cancer patients with life-limiting illness. Family caregivers have become increasingly responsible for providing home care for cancer patients.

A cross-sectional study was done among 20 family caregivers of hospitalized patients with advanced cancer in March 2013. Data were collected by interview technique from caregivers selected as per inclusion criteria for the study.

Result showed that majority of family caregivers were in the age group of 20-40 years (40%), most of the family members had to stop working, and most of them lost their savings. Majority of the family caregivers expressed that 'financial burden' had negative influence on the quality of life. The mean quality of life was 133.3 and standard deviation (SD) was 15.20.

Conclusion: The present study suggests that to improve QOL of caregivers, measures should be taken to decrease the economic burden that cancer places on patient's family. It also revealed that increasing the self-confidence of family caregivers in managing cancer pain is vital to the quality of life of both the patient and caregiver.

WHAT MEDICATIONS ARE OUR PATIENTS TAKING? AN AUDIT OF PRESCRIBED MEDICATION AND COMPLIANCE IN AN EAST AFRICAN NATIONAL REFERRAL CENTER

Rebecca S Evans, Claire SR Holmes, Mhoira EF Leng
E-mail: becievans@gmail.com

Introduction: Errors in prescribing, administering, or consuming medications can reduce effectiveness and could even cause harm. In Mulago National Referral Center patients or attendants administer oral medications, with minimal documentation to advise them, leaving potential for adverse drug events.

Objectives: To determine whether the patient prescription chart accurately describes the patients' current medications.

Method: An audit of patients referred to Mulago Palliative Care Unit (MPCU) during September 2013.

Prescribed medications were recorded and the patient and/or the attendant was interviewed to determine which medications they were taking. Data was analyzed using Excel.

Results: Data was collected from 18 patients.

Patients were prescribed an average of 2.6 medications, but were taking on average 4.1.

In two cases the medications prescribed matched those being taken (11%).

50.7% of drugs being taken were not prescribed and 21.3% of prescribed medications were not being taken.

Of patients taking morphine, 77.6% was not prescribed and 14.3% of prescribed morphine was not being taken.

Conclusion: In this setting it is not possible to determine which medications patients are taking from review of their prescription charts. Therefore, there is a potential for reduced effectiveness and increased adverse events.

An improvement is required in both medication prescribing and communication with patients. A plan is in place to disseminate results within the team and discuss with the pharmacy team with the hope of implementing change.

PILOT STUDY ON PREVALENCE OF DISTRESS IN VARIOUS STAGES OF COPD PATIENTS USING THE NCCN DISTRESSTHERMOMETER

Subhashini, Charu Singh, Chitra Venkateswaran
E-mail: subhashinim@aims.amrita.edu

Introduction: Chronic obstructive pulmonary disease (COPD) is a chronic disease that causes multidimensional distress in patients. COPD is associated with intermittent exacerbations characterized by acute deterioration in the symptoms. These acute exacerbations are the main cause for hospitalization in COPD patients and they are also associated with deterioration in health status and lung function. The mental health of COPD patients has received growing attention in the last few decades, with some studies finding psychological factors, like anxiety and depressive symptoms, to be better predictors of COPD-related quality of life than lung function. The chronic nature of the illness also has an effect on the social and financial aspects of the patient's life.

Aim: The study is mainly focused on assessing the distress in COPD patients seen in a tertiary care hospital using the distress thermometer. The study was conducted on COPD patients who visited the Department of Pulmonology, AIMS over a period of 2 months and met with the inclusion criteria. The severity of COPD and related degree of distress was also evaluated. The study also attempted to see how palliative care could aid in caring for these patients at different stages during the course of the illness.

Methodology: COPD patients were assessed based on the inclusion and exclusion criteria with valid tools.

Inclusion Criteria: COPD patients as diagnosed by their pulmonary function test (PFT),
No psychiatric co morbidities in the past.
No family history of psychiatric illness.
Exclusion criteria
Past history of psychiatric illness
Family history of psychiatric illness

Tools:

Sociodemographic performa
Distress thermometer
Results and Conclusions
Will be presented in the conference

INCOME GENERATION FOR A COMMUNITY-BASED PALLIATIVE CARE PROGRAM - SHARING BEST PRACTICE EXPERIENCES

Deepak Kumar
E-mail: deepak.kumar.rm@gmail.com

Introduction: The purpose of our research is to discover best practices for implementing an income generation program for the patients of Palliative Care Mysore, an initiative of Swami Vivekananda Youth Movement (an NGO located in Mysore, Karnataka, India).

Objectives: The objectives are is to discover practices which will allow patients to:

1. Provide patients an outlet to use their time constructively in a way which
    - relieves their mind of worry from any stress
    - allows for them to earn income for their families
2. Determine how to train patients in a cost-effective manner without compromising quality
3. Ensure products made by palliative care are set to a standard of quality and price
4. Experiment in marketing strategies.

Methods: The methods of Palliative Care Mysore have been to provide training to patients on handmade items such as umbrellas, coasters, bracelets, artificial jewelry, mats, dolls, greeting cards, and paper bags. Through learning experiences, successful products which patients/caretakers/volunteers are willing to create and are in high demand have been continued.

Results: Artificial jewelry, mats, coasters, bracelets, and umbrellas have sold well and the patients have responded positively to engaging in their creation. Patients show poor responses to doll making it requires much skill and time.

A goal for the future is to create a brand name for the products.

Conclusions: In conclusion, the program has seen success with several important products which patients are willing to create. Increased experimentation and implementation of new ideas will be a strategy for the future.

BUILDING CAPACITY FOR PALLIATIVE CARE IN RURAL NORTH INDIA

Chitra Venkateswaran, Ann Thyle, Charu Singh, Ed Dubland, Grahame Tosh, Mhoira Leng
E-mail: chitven@gmail.com

Introduction: Development of palliative care services in India is uneven with most provision and integration in the south. With the aim of improving palliative care services in rural north India and some states of west and northeast India, Cairdeas and Emmanuel Hospital Association (EHA) along with Pallium India has been focusing at building capacity from 2009.

Objective: To build capacity training the EHA team in palliative care, to reach out the marginalized rural poor. To develop training programs suited to settings and work culture

Methods: Basic palliative care training for the whole team in batches using the Palliative Care Toolkit and Trainers Manual. Development of five specific curricula for in depth training: (1) Leadership and management. (2) Teaching and training. (3) Self-awareness and teamwork. (4). Advanced communication skills. (5). Protocol-based symptom management. (6) Mentorship and supervision. External faculty support service evaluation and planning.

Results: All courses have been delivered and show early impact. Developing modules using tools with ease of use, have enabled building capacity in EHA which has reflected in establishing trainers, initiating in service training programs and starting new services in the community. Seven services have been initiated and one recognized as an Indian Association of Palliative Care (IAPC) training site. Peer support, training, and mentoring is ongoing. Two service evaluations inform the models of care.

REACHING OUT TO MARGINALISED POPULATION: THE WIDENING SCOPE OF PALLIATIVE CARE ON INCORPORATION OF EXISTING HEALTH CARE SYSTEM, A STUDY BASED ON THE DATA BASE OF A DISTRICT IN KERALA, INDIA

Shaji S Nair
E-mail: shajiyesnair@gmail.com

Introduction: Accessibility to specialist palliative care is out if reached to poor. The Government of Kerala under the auspices of the National Rural Health Mission envisaged a program so that the services could reach the door steps of poor and needy.

Purpose: The objectives of this study were to find out the number of patients receiving the specialist palliative care, number of non-governmental organizations (NGOs) involving in the provision of services, the most common pathological conditions, the challenges faced by the service providers and suggestions for improving the care.

Methodology: A retrospective desk review of the monthly reports sent to the District Medical Office, Thiruvananthapuram and Kerala for 12 months commencing from January 2012 to December 2012 was done. Findings of these documents were manually recorded on the computer and tallied. The results were then tabulated and presented.

Results: It was found that 1,00,000 patients are receiving specialist palliative care. The common conditions for which services rendered are (1) terminal cancer (10%) (2) end stage respiratory failure (5%) (3) end stage kidney failure (5%) (4) traumatic paraplegia (40%) (5) others (40%). The number of officials involved in care delivery are (1) accredited social health activist workers (40%) (2) JPHNs (7%) (3) JHIs (7%) (4) nurses (20%) (5) medical officers (2%). The number of NGOs supporting the delivery of care was 250. The continuum of care was maintained by conducting regular CMEs and the number of CME conducted was 150. The major challenges identified were (1) lack of awareness, (2) no proper management information system for documentation and reporting and (3) reluctance of private institutions to join hands with care provision. The suggestions for improving care include (1) incorporation of structured institutions like Christian churches, Rashtreeya swayamsevak sangh, political parties especially the Communist Parties in Kerala. (2) More involvement of media, through soap operas with palliative care as the main theme and (3) involvement of more Governmental and non-governmental agencies like Janamaithri Policing, college students and semi religious organizations.

Conclusions: Active participation of the whole health care system of the Government in liaison with non-governmental agencies is the most feasible way to impart specialist palliative care to the needy. It can reach the doorsteps, ensure a continuum of care and has a mass appeal. The palliative care movement in Kerala stands out as a role model for other states in India to initiate the program with same zeal and vigor.

INTERVENTIONAL PAIN PROCEDURES IN HOSPICE

Dr. Somnath Bagchi
E-mail: somnath.bagchi@tmckolkata.com

Introduction: Timely interventions in terminally ill-patients improve their quality of life, make them functional and increase their life expectancy. Here we are going to describe certain procedure, which can be done in a hospice or domiciliary settings with a help of ultrasound or landmark techniques. The type of blocks will depend on the areas affected, acceptability (consent) of the patient, doctors experience and infrastructure.

Methods: Pain from head and neck cancers can be managed by sub occipital decompression, greater occipital nerve blocks, intranasal sphenopalatine blocks, stellate ganglion ablations or infraorbital, supratrochlear nerves ablation or external neuromodulation (EN). Maxillary or mandibular nerves can be also be blocked. Rib metastasis, breast and lung cancers often involve the intercostal nerves and brachial plexus. These respond with intrathecal neurolysis with absolute alcohol. There are published case series of >400 cases with excellent results. Our series though small had good results. Pain in the abdomen are usually manages in our center by tunneled epidural. In UK the mixture infused is usually opioid based but in our setting we got excellent result with local anesthetic and ketamine. The catheters can be kept for 6-10 weeks before changing sites. Suprapubic pain due to recurrences following radical prostatectomy, cystectomy or major gynecological surgery responds well to EN.

Patients with rectal pain with colostomy can have intrathecal phenol to minimize pain. For more generalized pelvic pain repeated caudal epidurals can help. Isolated sacral or hip metastasis though responds well with bone cement injection but needs X-ray visualization.

Conclusion: The success of any block depends on proper patient selection and managing patient’s expectation.

TRANS NASAL SPENOPALATINE GANGLION BLOCK FOR HEAD AND NECK CANCER PAIN

Dr. Priti R Sanghavi, Dr. Geeta M Joshi, Dr. Bipin M Patel
E-mail: drpritisanghavi@gmail.com

Cancer pain is severe, intractable and sometime difficult to manage with conventional therapy. Sphenopaltine ganglion (SPG) is the one of the largest parasympathetic ganglion in the head and neck region and its block with local anesthetic provides immediate pain relief from head and facial pain. Hence the aim of this study is to observe efficacy of sphenopalatine ganglion block (SPGB) in providing immediate pain relief from cancer pain with little modification of technique of SPGB. During last 1 year from November 2012 to October 2013, trans nasal sphenopalatine was performed in 180 patients who had severe head and neck pain due to malignancy. 5 ml of injection bupivacaine hydrochloride 0.5% was used for block. Immediate pain relief, duration of analgesia, intensity of pain after 1 week and complications were noted. There were 122 male and 58 female patients. There was a significant reduction in mean visual analog scale (VAS) score from 8.566 ± 1.31 to 3.05 ± 0.0 ($P < 0.0001$) immediate after block. Intensity of pain was also reduced after 1 week which was observed by reduction in mean VAS score from 8.566 ± 1.31 to 5.2 ± 1.05 ($P < 0.0001$). Mean duration of analgesia was 5.303 ± 3.43 days. There was no serious side-effect.

Conclusion: SPGB with local anesthetic provides statistically extremely significant pain relief, it reduces the intensity of pain in subsequent days and so then pain is manageable with conventional therapy.