to 35% at six months post-surgery. At each time point fatigue was predicted by social support and trait anxiety, with the latter explaining the largest percentage of variance. Social support only remained a significant contributor for fatigue at one month.

Conclusion: Trait anxiety plays an important role in experiencing fatigue among women with early stage breast cancer. An intervention for women high on trait anxiety that is focussed on learning them to cope with anxiety and fatigue seems necessary.

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Personality does not influence the choice between breast conserving therapy and modified radical mastectomy in early stage breast cancer

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Background: In most cases of early stage breast cancer, there are two surgical treatment options. Women can choose between breast conserving therapy (BCT), i.e. lumpectomy and axillary lymph node dissection followed by radiotherapy, and modified radical mastectomy (MRM), i.e. removal of all breast tissue en bloc with the axillary lymph nodes. BCT is frequently promoted by the medical profession as the preferred surgical treatment in early stage breast cancer since it is less mutilating. However, fear of recurrence of cancer and anxiety may influence the choice of women and lead to MRM despite the mutilation. This study examined factors that may play a role in the choice for BCT or MRM.

Methods: Women with a first event of breast disease were asked to participate in a prospective study concerning quality of life (QOL). Before diagnosis was known, the women completed questionnaires on QOL, personality, depressive symptoms, anxiety, and demographic factors. Logistic regression analyses were performed to see whether any of the psychological and personality factors were of significance in the decisional process. Clinical parameters such as tumor size and treating surgeon were also analyzed.

Results: Three hundred and nine women agreed to participate in this study, of whom 119 patients were diagnosed with early breast cancer. Of them, 62 women choose breast conserving therapy. Only tumor size had a significant influence on the treatment choice. The mean tumor size in the BCT group was 15.2 mm and in the MRM group 20.6 mm ($p = 0.017$). Women with a larger tumor more often choose MRM. None of the other clinical parameters had a significant influence on the treatment decision. The majority of patients in both treatment groups scored high on the psychological factor state anxiety, 64.6% in the BCT group and 68.2% in the MRM group. So trait anxiety did not significantly influence the choice of treatment. In addition, none of the other personality characteristics and psychological factors appeared to play any role in the treatment choice.

Conclusion: International guidelines concerning surgical treatment of preference in larger tumors have a significant influence on the choice between BCT and MRM. In case of smaller tumors it is not anxiety but probably a ‘gut feeling’ that can not be defined at this moment that is important in the decisional process.

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Transforming the patient into “a personal client”, at the Breast Care Center

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The Breast Care Center treats the northern Israeli population that has clinical findings of the breast and follows high risk patients for breast cancer. Before April 2005 waiting time for various diagnostic examination and staging took between 3 to 4 weeks, wich caused the patients unnecessary tension. By reaching out to create personalized contact between the patient and the staff at the center we succeeded in reducing the maximum waiting time to conclude the testing to just 7 days. By doing so, received positive feedback from the patients.

Between April 2005 to August 2005, 3000 patients were referred to the breast center. Among them 156 were diagnosed as new cases of breast cancer. In order to reduce the length of time taken for diagnosis and staging, most of the procedures were concentrated under one roof. In reference to examinations that take place in other facilities we had permanent appointment times reserved to accommodate our patients.

The center’s nurses are in constant contact with the patient and know at any given moment what stage of progress the patient is in. In addition, every patient who is in the diagnostic phase appears in a special list in the department’s computer that allows us to follow all testing and results. The department social worker follows the patient and her family and tends to every emotional problem that arises from this situation. Later a survey was conducted among 92 patients diagnosed with breast cancer at the center. In the survey satisfaction of the swiftness of executing the testing, speed of receiving results and attitude of the staff to the patients were measured. The patients were asked to grade their satisfaction on a scale of 1–5, 5 being the highest grade of satisfaction.

Between 91% to 95% of those surveyed stated high satisfaction with the speed of the testing and obtaining result. Between

98% to 100% stated high satisfaction from the staff attitude. In regard to mental support from the staff, 79% were very satisfied with support from the doctor, 90% were highly satisfied with the support from the nurse.

Our conclusion is that close follow up of the patients who are being diagnosed and staged raises the efficiency of the center by quicker execution of testing. Close follow up of the patients and creation of personal contact for the duration of the process, thus,transforming the patient into a “personal client” raises the threshold of satisfaction from the center and the staff, and lowers anxiety level.

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Psychosocial needs and communication as main early determinants of quality of life in women with non-metastatic breast cancer

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REPERES is a research project which intends to evaluate the health network organisations performance.

The **Objective** of the present study is to evaluate the early determinants of quality of life (QoL) in women with non metastatic breast cancer. The determinants could be clinical, socio-demographic factors, or linked with non biomedical elements of care.

Methods: A population-based sample of women with non metastatic breast cancer traited in 2 French areas since 2003 was constituted. They completed the European Organization for Research and Treatment of Cancer QoL questionnaire (EORTC QLQ-C30), 1 month after adjuvant therapy. Regression models calculated mean QoL scores of 2 dimensions “global health and QoL” (Ql) and “Emotional” (Ef) across cancer stage, surgical treatment, chemotherapy, comorbidity, age, education level, socio-professional category, family situation, information and communication, influence and presence of relatives, personal seek of information, treatment agreement and psychosocial needs perceived at the diagnosis announcement.

Results: First results on 508 patients showed that women reporting problems of communication or psychosocial needs scored statistically significantly lower on both dimensions. Besides, women whith higher level of education, reporting no seek of information but questions to ask scored higher in Ql. Women whose relatives were present at the diagnosis announcement scored lower in Ql. Women with high socio professional category, who lived alone scored higher in Ef. However this score was lower in women with psychological comorbidity or under the influence of their relatives about their care.

Conclusion: As previous recent studies, those results confirm the importance of communication and consideration of psychosocial needs in QoL outcomes. Other results need to be confirmed and interpreted regarding satisfaction outcomes.