

2 years of the follow-up period. Meanwhile, the prevalence of RI increased, reaching 62.9% and 17.5% for a GFR <90 and <60, respectively at T24 (table). Among the 641 patients with a SCR available at T0 and at T24, the GFR decreased from 89.7 to 83.7 mL/min/1.73m² ($p < 0.001$) over the 2 years of the follow-up period (table). Furthermore, 41.6% of those with a GFR ≥ 90 at T0 had a GFR <90 at T24. Furthermore, 17.7% of patients with mild renal insufficiency (60 to 90) at T0 had a GFR >60 at T24.

Conclusion: IRMA-2 shows that renal function decreases rapidly in cancer patients with a loss in GFR of 3–3.5 mL/min/1.73m² per year. This suggests that cancer patients are more exposed to a deterioration of renal function and that it should be closely monitored with at least a regular estimation of renal function, for instance every 6 months. So far, such a follow-up is not performed in clinical practice. Furthermore, drug therapy should be reevaluated, dosages adjusted when necessary, and some potentially nephrotoxic drugs changed for less or non-nephrotoxic drugs if possible.

Table. Renal function among the 641 patients with an available SCR at T0 and T24

GFR (mL/min/1.73m ²)	T0	T24	Delta (T24 – T0)	p-value (between T24–T0)
Mean GFR	89.7	83.7	– 6.0	$p < 0.001$
GFR <90	55.7%	62.9%	+7.2%	$p < 0.001$
GFR >60	11.5%	17.5%	+6.0%	$p = 0.001$

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POSTER DISCUSSION

Evaluation of psycho-social distress in patients treated in a community based oncology group practice in Germany

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Background: Systematic evaluation of psycho-social distress in oncology outpatients is an important issue. Therefore we assessed feasibility and benefit of standardized routine screening using the Distress Thermometer (DT) and the Problem List (PL) in daily practice.

Materials and Methods: All patients attending the practice between July and September 2008 were administered the DT and the PL. Patients were classified into the disease groups solid tumors, hematological neoplasms, benign hematological diseases and other non-malignant diseases. The individual treatment phase was evaluated additionally. Participants in a mammography screening programme were assessed as a control group. 500 randomly selected patients were sent a feedback-form to describe how they experienced the DT's influence on the doctor-patient-communication.

Results: 1446 patients were included and reported an average distress level of 4.7. 37% indicated a distress level >5. The highest average distress level of 5.2 was seen in patients with other non-malignant diseases (81% autoimmune diseases or hereditary hemochromatosis). Concerning the treatment phases, the most distressed patients were patients who just learned about their diagnosis of relapsed or metastatic disease (6.4), patients receiving Best Supportive Care (5.4) and patients receiving adjuvant anti-hormonal therapy (5.4). The most frequently indicated problems causing distress were exhaustion/fatigue (49%), pain (44%), impaired mobility (41%) and sleep disorders (39%) respectively. A significant correlation existed between the distress score and the total number of stated problems as well as between the number of emotional problems and the number of physical problems. Breast cancer patients stated a distress level of 5.2. The average distress level in mammography screening participants was 3.3. 97% of patients who returned the feedback-form indicated that they appreciated to speak to their doctor about their distress. 56% of distressed patients felt better than usual after this consultation.

Conclusions: The study shows that cancer patients do not necessarily show higher distress than patients with severe non-malignant diseases. The problems patients most frequently indicate as distressing are somatic disorders. DT and PL are applicable for routine screening in an outpatient setting. Physicians as well as patients stated that the use of the DT improved the quality of their communication.

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POSTER DISCUSSION

Prevalence and causes of burnout syndrome among oncology residents in France: a comprehensive cross sectional study

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Background: Burnout syndrome is frequent among oncology healthcare workers. It leads to deterioration of physicians' health and quality of life. It also probably discourages vocations for oncology and has a detrimental effect on patient-physician relationship. Little is known, however, about the prevalence and causes of burnout among oncology junior doctors.

Material and Methods: A questionnaire was sent out to every medical or radiation oncology resident in France (n=215). The survey was anonymous and confidential. It was divided into seven parts: demographical data, burnout level (Maslach Burnout Inventory, MBI), type of stressors, emotional work, sense of equity at work, type of support, general health level and alcohol/drug intake. Validated scales were used when available. Two reminder e-mails were sent out to increase response rate.

Results: Questionnaires were sent on March 1st 2009 and collected until April 20th. One hundred and fifty four questionnaires were returned and analyzed. The response rate is 72% (154/215). Emotional exhaustion (EE) and Depersonalisation (DP), the major components of burnout syndrome, were reported respectively by 25% (n=39, CI95% = [0.19, 0.33]) and 38% (n=59, CI95% = [0.31, 0.46]) of the residents. Burnout prevalence was 42% (n=64, CI95% = [0.34, 0.50]), defined by a severely abnormal level of either EE or DP scores. Twenty percent of the residents (n=31, CI95% = [0.14, 0.28]) had severely abnormal levels of both EE and DP. Burnout was associated with a lower perception of one's general health status (good/very good versus average/poor, $p = 0.0006$). Burnout level is higher among residents who don't feel adequately rewarded for their work and commitment (OR=2.5; $p < 0.01$). No demographical characteristics (age, sex, marital status, length of service) were predictive of burnout. Prevalence of burnout was not significantly different between radiation and medical oncology residents ($p = 0.55$).

Conclusion: Burnout level is high among oncology residents. Multiple factors can be involved: young age, lack of experience, work overload, and the fact that residents mostly face seriously ill patients or end of life situations. Interventions are needed to improve this situation, such as support groups, more intense coaching by senior physicians, training programs on "breaking bad news" and teaching of stress management skills.

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POSTER DISCUSSION

Service patterns of integrated oncology and palliative care, focused on interdisciplinary outpatient clinics

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Background: Palliative Cancer Care (PCC) delivers multidimensional symptom staging and control, sequential decision making processes fostering patient-priority and goal-directed interventions including anti-cancer therapies, communication interventions, family care, and support networks of in- and outpatient clinics and community. We aim to test the hypothesis, that distinct service patterns can be identified in a setting of an ESMO-designated center of integrated oncology and palliative care.

Methods: All service contacts following the first outpatient PCC clinic visit (including 1. interdisciplinary clinic focused on nutrition and fatigue, 2. Supportive-palliative nurse-physician-clinic, 3. physician-based clinic) were tracked for date and type (emergency unit, inpatient palliative care unit, inpatient oncology clinic, hospital palliative care mobile team, palliative care bridge service, home care nurses and general practitioners (GP)). The time and location of death was identified through charts and GPs. Patterns of integration of oncology and PCC (Pa-IOP) were characterized in calibration sample of patients, definitions where refined until consensus was reached. Then the whole sample was analyzed.

Results: The PCC outpatient clinic included 373 patients (230 male, 143 female; median age 63.5; with mixed tumor types (16% lung, 15% colorectal, 7% prostate, 12% ovarian, 50% other) having over 2000 consultations (1 visit: 113; 2–5: 134; 5–10: 46; >10: 60). The time range