from first contact until death ranged from 320 days (prostate) to 72 days (urothel), for lung cancer 138 days, for colorectal 204 days. The time from stage IV to first PCC outpatient contact was 310 days for lung, 492 for colorectal cancer. The time from first contact with palliative care of patients seen first in the palliative care inpatient unit, or the hospital mobile team was substantial shorter time.
Identified Pa-IOP include a) focused one time visit in the outpatient unit, b) a PCC staging based on a standard situation (e.g., new stage IV, progression), c) shared care with alternating visits by oncologists and the PCC outpatient clinic, d) taking over care by the PCC team. Patient characteristics and outcomes of patients cared for by the four Pa-IOP are currently analyzed.
Conclusion: Identification of different service patterns of integrated oncology and palliative care and associated patient characteristics and outcomes, including defined palliative cancer care interventions, may support development of tailored and efficacious services and improve patient care.

3012 POSTER DISCUSSION

Cancer rehabilitation programme – finding a new balance

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Cancer and its treatment can give rise to long-term consequences such as fatigue, lack of energy, or changes in self image. A cancer rehabilitation program may help patients finding a new balance in their life once anticancer treatment has been completed. Due to the impact on quality of life but also on survival rates rehabilitation programs are becoming more important.
A multidisciplinary rehabilitation program, based on the 'Herstel and Balans' Program consisted was offered to adult cancer patients who finished an anticancer treatment with curative intent. The 12-week group program combines physical training and psychological support. Twice weekly participants are trained to improve their physical abilities by fitness, group sports and hydrotherapy under supervision by physiotherapists. The psychological support includes psycho-educative group sessions on several aspects (e.g. fatigue, diet, intimacy, stress and coping) and individual support, if indicated. All psychological sessions are under guidance of psychologists. The outcome was measured by physical tests, by the EORTC QL and FACT questionnaires and by a qualitative analysis. Since 2004, 228 people participated in the revalidation program organized by the "Ziekenhuisnetwerk Antwerpen (ZNA)-Middelheim". Repeated measures showed an improvement in physical ability, an increased quality of life and a decreased fatigue. The program had a satisfaction index of 95%. Qualitative analysis show that participants regained confidence and tried to pick up work and other interests.
Our results support the integration of a rehabilitation program in the daily care of cancer patients treated with curative intent.

3013 POSTER DISCUSSION

Performance of medical oncologists on end-of-life care for Taiwanese cancer decedents, 2001–2006

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Background: Oncologists play a significant role in cancer care throughout the cancer trajectory and have traditionally emphasized underuse of procedures or treatments with well-established effectiveness as the source of poor care quality with little attention to the overuse of end-of-life (EOL) care. The purpose of this population-based study was to compare EOL care practices in Taiwan between medical oncologists and other physician specialists.
Methods: This retrospective cohort study compared indicators of poor quality EOL care by examining administrative data for a cohort of 204,850 cancer decedents in 2001–2006.
Results: Taiwanese cancer patients whose primary physician was a medical oncologist were significantly more likely than patients with a non-oncologist primary physician to receive chemotherapy (AOR: 3.45, 95% CI: 3.03−4.00) and to spend more than 14 days in a hospital (AOR: 1.11, 95% CI: 1.04−1.19) in the last month of life. However, they were significantly less likely than patients with a non-oncologist primary physician to visit the ER more than once (AOR: 0.88, 95% CI: 0.81−0.96), and to use ICU care (AOR: 0.32, 95% CI: 0.22−0.48), cardiopulmonary resuscitation (CPR) (AOR: 0.71, 95% CI: 0.64−0.80), intubation (AOR: 0.60, 95% CI: 0.51−0.70), and mechanical ventilation (AOR: 0.46, 95% CI: 0.39−0.54) in the last month of life.
Conclusion: Cancer decedents cared for by medical oncologists had a greater likelihood of receiving chemotherapy and prolonged hospitalization but a lower propensity for multiple ER visits, ICU care, and undergoing CPR, intubation, and mechanical ventilation in the last month of life than patients with other types of physicians.

3014 POSTER DISCUSSION

Symptoms, care needs and type of cancer diagnosis in palliative cancer patients in acute care hospitals

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Background and Aim: Palliative cancer in acute hospitals is scarcely studied. We therefore explored the symptoms and care needs of palliative cancer patients and the relationship between diagnosis and symptom related reasons for care during hospitalization.
Material and Methods: Two acute care hospitals in a county with no advanced palliative home care service 24/7. One-day-inventories on 16 occasions in 14 different hospital wards during 2007. On each ward every patient day was classified as "palliative" or "not-palliative" and symptoms were registered according to a check-list. Multiple logistic regression models were used to check associations between symptoms and type of cancer.
Results: Out of 4364 patient days 613 (14%) were classified as palliative; 453 (10%) as cancer palliative days, and 160 (4%) non- cancer days. Of the 453 cancer patient days, 358 were for individual patients; 200 (56%) were men and 158 (44%) were women. Mean age 74 years. The seven most common cancers were prostate 14%, colon/rectum 13%, lung 12%, pancreas/gallbladder 12%, hematological 12%, urinary tract 8% and unknown primary 7%. The seven most common symptoms and needs were detoriation (43%), pain (42%), infection (25%), nausea (18%), social problems (16%), infusion (15%) and blood transfusion (12%).
In men, pain was associated with prostate cancer (OR 2.8 95%CI 1.4−5.7), nausea with pancreas/gallbladder (OR 3.2 95%CI 1.4−7.1) and gastric cancer (OR 5.6 95%CI 1.9−16.7). Infusion/nutrition was associated with gastric cancer (OR 8.2 95%CI 1.6−41.9), hematological malignancies (OR 7.5 95% I 2.3−24.3) and pancreas/gallbladder cancer (OR 6.0 95%CI 1.7−20.8). Infection was associated with hematological malignancies, both for men (OR 11.8 95%CI 4.4−31.6) and women (OR 8.8 95%CI 2.9−26.7). In women, pain was associated with cancer of the urinary tract (OR 12.4 95%CI 1.8−86.0), pancreas/gallbladder (OR 4.2 95%CI1.5−11.9) and colon/rectum (OR 3.1 95%CI 1.2−8.6). Social problems were associated with breast cancer (OR 4.1 95%CI 1.3−12.6) and unknown primary (OR 4.9 95%CI 1.4−17.5).
Discussion: Although we do not know all the causes of the hospital care this study indicates that focus should be on the symptoms instead of the specific cancer diagnosis. The study also indicates that many palliative cancer patients' problems are suitable for advanced palliative home care instead of acute care hospitals.

Poster presentations (Tue, 22 Sep, 14:00−17:00)
Symptom science

3015 POSTER

"Pain gets you down" – a project to control pain in cancer patients

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In the Ziekenhuisnetwerk Antwerpen (ZNA)-Middelheim, a pilot project showed that pain was prevalent in both oncologic (n = 60) and non-oncologic patients (n = 43) with pain scores as measured by visual analogue scale (VAS) (range 0−10) of 1−3 in 33% and 14%; of 4−7 in 17% and 19%; and 7−10 in 1% and 7% respectively. It was also demonstrated that the nursing staff could evaluate pain by VAS and this led to the