3606 POSTER

Cancer control programme by training of the rural medical practitioner by work up and continuation of the programme using telemedicine system – a project from West Bengal, India

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Background: In India, total cancer burden is more than 25 lacs and there is an increment of 10 lacs new patients per year, which is 1/10 of total cancer burden in the world. Majority of the cancer in this part of the country are tobacco and diet related. It is estimated that, by proper preventive measures we can reduce the current level of increment of 1,00,000 annually by 2020. Rural health system in West Bengal is mainly dependent on rural medical practitioner and health workers. 80% of the services are rendered by the unqualified practitioners and health workers. The aim of our state based non-Governmental cancer control programme is to reduce the cancer burden by proper awareness among rural medical practitioner and health workers. We also intended to teach them about symptoms of cancer and pick up cancer in early stage to provide appropriate treatment.
Material & Methods: During the period of January 2009 – December 2011 a cancer screening and awareness programme is being conducted in various districts of West Bengal twice in every month by NCRI. There are 7 peripheral centres in 7 different district places of West Bengal. First of all 2 days training by workshop are being conducted among the rural practitioners. They are taught about dealing about oral cancer by examining the oral cavity, any history of tobacco intake, breast cancer by self breast examination and cervical cancer by Pap smear examination. Hands on experience are given to them by video presentation and practical demonstration. The cases which are detected positive are sent to our hospital for planning of appropriate treatment and advanced cases are advised for pain and palliative treatment in the peripheral centres. The peripheral centres are connected with the main centre, NCRI, by telemedicine.
Result: In this Govt. of India funded project, a total of 30,000 rural medical practitioners and health workers are being trained. 10 blocks around each centre are being selected. In the ongoing process over 3 years it is estimated that 70 lacs population will be covered by the rural medical practitioner and health workers for awareness and early detection cancer.
Conclusion: At the present scenario, 80% of the patients are detected in advanced stage and they are not being properly treated. We hope, by our present project, more than 80% of population in the covered area will be detected early and get appropriate treatment in time.

3607 POSTER

Organisational hazards when treating patients with cytotoxic drugs

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Background: Due to a couple of lethal accidents with cytotoxic drugs a risk assessment was called for, as a possible driver for process re-engineering.
Material and Methods: A proactive risk analysis method, DEB (Deviation-Effect-Barrier) analysis [1] was applied to the process "Treatment of patients with cytotoxic drugs", at a department of oncology. In the analysis latent failures were identified, the strength of existing safety barriers assessed, and suggestions made for implementing of new barriers or strengthening of old ones.
Results: The study identified a number of latent failures:

1. The procedures for updating the manual for chemotherapy regime are unsafe.
2. The procedures for cooperation between department of oncology and pharmacy are implicit and not clear.
3. Responsibility and authority for the nurses are not defined.
4. Necessary competence for doctors is not properly defined.
5. The procedures for evaluation of the results of blood tests are unsafe.
6. The procedures for tracing the results of blood tests are inappropriate.
7. The procedures for transfer of information from manual to CTC (Cytotoxic Treatment Card) is inappropriate.
8. The procedures for filling in the CTC are unsafe.
9. The procedures for marking the CTC with proper patient ID are unsafe.
10. The technical equipment (infusion pumps) is of different brands at different ward units at the department of oncology.
11. The procedure for monitoring the patient during treatment is unsafe.

The most dangerous errors were:

- Clinical misjudgement of the patient before prescription
- Misjudgement of laboratory results
- Necessary blood tests not taken
- Blood test results are forgotten
- Errors in prescription and errors in filling in the cytotoxic treatment card
- Wrong infusion administered to the patient (wrong drug, wrong amount, wrong infusion rate).

Conclusion: Overall, the safety barriers at the ward unit were weak or non-existent. Several error opportunities could be reduced by computerisation of key tasks.
Based on the findings from the study a generic checklist for hazard identification was proposed.
Due to the study a re-engineering of the studied process took place.

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3608 POSTER

Development of a post adjuvant exit lifestyle toolbox

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Background: An increasing number of randomised trials are providing evidence that an optimal lifestyle after cancer can improve disease-free survival and overall chance of cure. Despite this, very few oncology units have integrated lifestyle strategies as part of their adjuvant management.
Materials and Methods: This two-year project involved patient volunteers, personal fitness instructors (PFI) and healthcare providers, including primary care trusts (PCT) representatives. The first phase involved a MEDLINE, Proquest, EMBASE and Cochrane Library search for literature addressing the benefits of lifestyle after cancer [1]. These data provided a foundation for a lifestyle manual and supporting lifestyle website [2]. It also convinced the PCTs to extend funding for their "exercise prescription programme", to include cancer rehabilitation. This required extra training for the PFIs to meet the standards determined within the 2001 Department of Health exercise referral document [3]. A cancer rehabilitation course was therefore designed in conjunction with a national training organisation, which provides a level 4 accreditation for PFIs. Finally, a convenient sized hand-held file was designed with feedback from our volunteer groups.
Results: This project has enabled us to successfully implement the UK's first post-adjuvant lifestyle toolbox, and establish Europe's first cancer rehabilitation training programme for PFI. Patients now receive an exit lifestyle interview, a prescription for an exercise programme supervised by a trained PFI in a local gym and a hand-held file containing a "Lifestyle after cancer manual", explaining the benefits of healthy living advising "What to do more of" and "What to avoid".
Conclusions: An evidence-based exit lifestyle toolbox has now been established. All UK oncologists can now write exercise prescriptions for their patients' exiting adjuvant therapies, and the training programme established in this project will ensure PFI have the necessary skills. The next stage in this project is to evaluate the impact of this strategy on patients' lifestyle choices.

References

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3609 POSTER

An economic analysis of arthralgia/myalgia versus recurrence in women with hormone receptor-positive (HR+) breast cancer (BC) on aromatase inhibitors (AIs)

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Background: The symptoms of arthralgia/myalgia (A/M) are associated with estrogen suppression and are more common with AIs relative to tamoxifen (TAM). AIs have demonstrated superior efficacy when compared with TAM. In the Breast International Group (BIG) 1−98 trial, letrozole (LET) treatment significantly reduced the risk of distant metastasis (DM). The updated 76-month BIG 1−98 analysis suggests that early reduction in DM ultimately leads to overall survival (OS) benefit; there were 40 fewer deaths with LET compared with TAM (Mouridsen H. *Cancer Res.*