coping. During the last months of the treatment, the expectations change over to questions about the future.

Table 1. Cognitive expectations under chemotherapy treatment

Time	Cognitive expectations identified	Reference
Start to 1 month	All possible information	McCaughan & Thompson 2000
	Treatment procedure and drug administration	Lock et al 2002
	Diagnosis, prognosis, treatment, support services, examination, aftercare and impact of illness	Vogel et al 2000
	Side-effect preventation, how chemotherapy works, how chemotherapy affects body	Knowles et al 1999
1 month to 5 months	Side-effect preventation, how chemotherapy works and how it affects body	Knowles et 1999
	How treatment influence daily living, how other patients experienced and coped	Friis et al 2003
	How to deal with emergency, diagnosis, aftermath of chemotherapy, duration of treatment	Iconomou et al 2002
	Illness, recovery, treatments, side-effects and trajectory of illness	Piredda et al 2008
Last course	Information of examination and medical tests	Vogel et al 2000
	Treatment completion, success of treatment, symptom recurrence and follow up arrangements	Skalla et al 2004
	Structured and detailed plans for palliative treatment and supportive care plans	Friis et al 2003

4233 POSTER

The impact of cytoreductive surgery and hyperthermic intraperitoneal chemotherapy on the experienced Quality of Life during the first two months after procedure

P. Bottenberg[1], Y. Heddes-te Winkel[1], V. Verwaal[1], E. van Werkhoven[1]. *[1]NKI – AVL, Surgery, Amsterdam, The Netherlands*

Background: Since 1995 cytoreductive surgery and hyperthermic intraperitoneal chemotherapy (HIPEC) is performed in the Dutch Cancer Institute – Antoni Van Leeuwenhoek Hospital (NKI – AVL). During this period nurses have observed an impact of the HIPEC on the experienced Quality of Life (QoL) of the patients. Therefore was the objective of this study to investigate the impact and the effect of surgery induced factors on QoL in the first 2 months after surgery.
Patients and Methods: In the period July 2006 – August 2008 29 patients with peritonitis carcinomatosa of colorectal origin were asked to fill in QoL questionnaires. 17 patients completed all forms. The drop out of 12 patients was due to re-admission ICU (2), transfer to another hospital (1), delirium on ICU (1), death (1) and forgetfulness (7). Of the 17 patients 8 are male and 9 are female. The average age is 54.4 year (range 34−73 years).
The QoL was measured with the EORTC QLQ-C30 questionnaire in a time span of 2 months: 1 day before, 2 weeks and 2 months after surgery.
The surgery induced factors were divided in length of admission (long term $\geqslant$16 days, 8 patients and short term <16 days, 9 patients) and in complications after surgery (relaparotomy, fistulas and disturbed wound healing; uncomplicated 10 and complicated 7 patients).
Results: The overall experienced QoL of all 17 patients showed a decline 2 weeks after surgery but increased to 68% of the baseline measurement 2 months after procedure.
The effect of the length of admission was not significant different in both groups. Also there was no significant difference when measuring the effect of complications on the experienced QoL.
Discussion: In this study we did not find a significant difference in QoL between complicated/not complicated patients and short/long term hospital admission. There are a number of draw backs in this study. The most important is the inability of sick patients to fill in forms; this is most clear in ICU patients. Because of the lack of validated tests of QoL for ICU patients, no answers could be given for this first period after treatment. Subsequently a critical reconsideration of assessment time is necessary. The small number of patients is also an important draw back.
Conclusions: Though patients experience a decrease in quality of life after surgery, this recovers during time. This empiric knowledge can be used in the information that patients receive (e.g. of nurses) before and during hospital admission.

4234 POSTER

Difficulties of access of an holistic care program for oncology patients in the Milan territory, Italy, a non profit association experience: Guida ONLUS

D. Anelli[1], M. Bottoni[2], R. Di Credico[3], D. Lichosik[4]. *[1]L'IPERBOLE/GUIDA ONLUS, Roma, Italy; [2]L'IPERBOLE/GUIDA ONLUS, Roma, Italy; [3]GUIDA ONLUS, Milano, Italy; [4]AIAO, Milano, Italy*

Background: The Milan, Lombardy, Italy area has been shown important difficulties for a family with one of its members suffering from an oncological disease to orientate and find information about social and sanitary services either public or private available in the territory.
Material and Methods: Retrospective analysis of the activity of a non profit association Guida ONLUS, that shares information and attend to the orientation of the sick person and their family towards social and sanitary services public and private existing in the territory of the Milan area in the past five years. Analysis of the requests presented by the families and by the patients to face the oncological pathologies.
Results: The data we have demonstrates that the families cannot find an unique interlocutor that can guide them towards the most suitable services for their needs this situation requires from the families huge commitment in terms of physical and mental energy as well as economical resources to locate, understand and access the care services available than can better satisfy their eminent and future needs. The accessibility of the information does not use telematic channels and has temporary limited windows of access that reduce the knowledge and accessibility of the service itself and as a consequence does not satisfy the needs of the family.
Conclusion: We think that is necessary to create a unique reference centre that is able to guide every single family towards the most suitable social or sanitary service available in order to deal, in an holistic way, with the needs of care during hall of the oncological illness phases of one of its members.

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Poster presentations

Managing cancer services

4235 POSTER

Involving people of diverse ethnicities in cancer research: an exploration of experiences, attitudes and barriers

I. Okamoto[1], D. Wright[2], Y. Gunaratnam[3], P. Cotterell[1], C. Foster[1]. *[1]University of Southampton, School of Health Sciences, Southampton – Hants, United Kingdom; [2]Macmillan Cancer Support, Research Manager, London, United Kingdom; [3]Goldsmiths College University of London, Department of Sociology, London, United Kingdom*

Background: Patients from minority ethnic groups are under-represented in cancer research, resulting in services and therapies that may be inappropriate or unable to meet their needs. This UK study aims to identify research experiences of cancer patients from minority ethnic groups; barriers to their involvement in research; and experiences and strategies of research nurses seeking to involve minority ethnic groups.
Material and Methods: Semi-structured and narrative interviews were conducted with 22 adult cancer patients and 8 research nurses. Patients were purposively sampled by ethnicities (South Asian, Chinese, Black African/Black Caribbean), languages (Hindi, Gujarati, Urdu, Punjabi, Cantonese, Mandarin, English), research experience and gender. The data were analysed using thematic analysis.
Results: Patients who had participated in cancer research in the past generally showed positive attitudes towards their experiences. They were also happy to take part in future research due principally to access to treatment and altruism. For those who had decided not to take part in research previously, the timing of recruitment, the risk of participating in research, and the type of research were factors which affected their decision-making. Patients and nurses identified the following potential barriers to involving minority ethnic patients in cancer research.

1. General concerns about participating in research
2. Demands of participation
3. Language and communication
4. Patients' different understanding of cancer and research
5. Influence of family and community