

BIA measurements: Resistance (R - Ohm), Reactance, (Xc - Ohm), total body water (TBW - through proxy measurement using height/resistance [Ht^2/R]), Phase angle (PA) and BIA vector analysis (BIVA) were used to compare for differences in hydration based on WHO performance status (0= asymptomatic, 4=bedbound), symptoms, physical examination and biochemistry.

Results: From a possible 118 patients, 90 (76.3%) provided consent. Ht^2/R was lower in patients with a WHO performance status of 4 compared to those with a performance status < 4 (mean 43.0 [SD 9.0] vs. 53.6 [SD 15.9], $p=0.001$), and greater in those with clinically detectable oedema (mean 60.37 [SD 19.2] vs. 47.8 [11.8], $p=0.004$). Ht^2/R correlated negatively with thirst [$r=-0.29$, $p=0.006$], dry mouth [$r=-0.336$, $p=0.001$], nausea [$r=-0.226$, $p=0.032$], unpleasant taste [$r=-0.282$, $p=0.007$], fatigue [$r=-0.315$, $p=0.002$]. BIVA showed significant difference in hydration between groups classified by the presence or absence of oedema ($p=0.0036$), and dry mouth ($p=0.01$). There was no significant relationship between hydration (Ht^2/R and BIVA) vs. biochemical tests or between symptoms vs. biochemistry or performance status.

Conclusion: In advanced cancer, hydration status (as measured by Ht^2/R and BIVA) relates to clinically measureable signs and symptoms. Further work is needed to determine whether BIA can be used to guide the management of fluid states in advanced cancer.

Abstract number: P217

Abstract type: Poster

What is the Most Appropriate Time Frame for Assessing Symptoms? A Validation Study of the Edmonton Symptom Assessment System-Revised (ESAS-R) in Advanced Cancer Patients

Nekolaichuk C.¹, Watanabe S.^{1,2}, Mawani A.²

¹University of Alberta, Oncology, Edmonton, AB, Canada, ²Cross Cancer Institute, Edmonton, AB, Canada

Aim: The Edmonton Symptom Assessment System (ESAS) is a widely used symptom assessment tool developed for advanced cancer patients. In response to recent concerns regarding the ESAS, a revised version, the ESAS-r, was developed. The ESAS-r offers distinct advantages over the ESAS, by revising problematic items, while still retaining core elements of the ESAS, including assessing symptoms “now.” Validity evidence is needed to determine an appropriate time frame for assessing symptoms and to compare the tool with similar measures.

Purpose: The overall aim of this study was to gather validity evidence by assessing differences in ESAS-r responses between “now” and “24 hour” assessments, as well as comparing the ESAS-r with a quality of life measure, with symptoms rated “over the past 7 days.”

Methods: 32 cognitively intact advanced cancer patients receiving palliative care services in a tertiary cancer facility completed two versions of the ESAS-r: Form A (rating symptoms “now”) and Form B (rating symptoms “during the last 24 hours”), as well as the EORTC QLQ-C15-PAL, a quality of life measure designed for palliative care. Correlations were calculated using Spearman’s rho (r_s).

Results: Most patients were women (56%), married (72%) and outpatients (75%); average age=61 (SD 9). Forms A and B were moderately to highly correlated for total symptom distress scores (SDS) ($r_s=.90$) and individual items, ranging from .70 (drowsiness) to .87 (depression). Total SDS for Forms A and B were moderately correlated with the total score for the QLQ-C15-PAL ($r_s=.67$ and .65, respectively).

Conclusions: Using a time frame of “now” versus “during the last 24 hours” did not substantially influence patients’ responses in this predominant outpatient population. The moderately high correlations between the QLQ-C15-PAL and Forms A and B suggest that the ESAS-r is effective for assessing quality of life. Further validity evidence using larger non-metastatic and non-cancer samples is warranted.

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Family Management Style Framework and its Use with Families who Have a Child Undergoing Palliative Care at Home

Bouso R.S., Santos M.R., Mendes-Castillo A.M.C., Misko M.D., Rossato L.M.

University of São Paulo, São Paulo, Brazil

Background: Palliative care settings in many countries acknowledge families as their prime focus of care, but in Brazil, to date, researchers have devoted scant attention to that practice setting. In this study, we aimed to explore how families define and manage their life when they have a child or adolescent undergoing palliative home care.

Methods: Data included individual semistructured interviews with 14 family members of 11 different families. Interviews were transcribed and the coding procedure featured qualitative content analysis methods. The deductive coding was based on the major components of the Family Management Style Framework (FMSF) and the eight dimensions comprising these components.

Results: The analysis provides insight into families’ daily practices and problems inherent in managing their everyday lives that are encountered when they have a child in palliative care. The study supported the usefulness of the FMSF for specifying unique areas of family strength and difficulty in the management of a child in palliative care at home. Recurring themes covering social, emotional, and physical aspects in the family interviews suggest useful

issues to consider in the development of a palliative care program and point to the importance of addressing family grief as part of pediatric palliative care at home.

Discussion: Palliative care claims a holistic and family centered view, and, the literature argues, we can extend and intensify our quality of care by challenging assumptions based on our own culture. Many professionals, including those in Brazil, continue to look more at the purely medical/biological situation and find it difficult to assess family relationships and intervene in them if necessary. To advance in the training of health professionals for work in family care in palliative care situations, we must adjust or approximate the family assessment tools to the Brazilian reality of the health care professionals involved.

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Family Caregivers' Perceptions of Depression in Patients with Advanced Cancer: A Qualitative Study

Rhondali W.^{1,2}, Chirac A.¹, Laurent A.¹, Terra J.-L.³, Filbet M.¹

¹Hospices Civils de Lyon, Centre de Soins Palliatifs, Lyon, France, ²MD Anderson Cancer Center, Palliative Care, Houston, TX, United States, ³Centre Hospitalier du Vinatier, Bron, France

Background: Depression is a serious issue in cancer patients, resulting in impaired quality of life and probably shorter survival. However, many cancer patients with depression are not treated because of the difficulties in identifying depression in this population. Our study aimed to examine caregivers' perceptions of depression among advanced cancer patients.

Methods: This qualitative study used semi-structured interviews, and we analyzed data using grounded theory and qualitative methods. We recruited caregivers from our Palliative Care Unit (PCU) in an Academic Medical Center.

Results: We interviewed 15 caregivers. Cancer patients' caregivers had a good theoretical knowledge of depression but also acknowledged that in the context of cancer and because of their relationship with the patient, identification of depressive symptoms could be challenging. They considered themselves as partners in the patient's care with a supportive role. However, by assuming the role of partner in patient care, caregivers exposed themselves to emotional difficulties and an increased need for support and information.

Conclusions: Our results suggest a significant impact of depression in advanced cancer caregivers and it is therefore crucial that health care professionals develop education programs targeting cancer patients' families as well as specific interventions to minimize the impact of the burden of patient care on caregivers.

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Bereavement Support in Palliative Care in Portugal

Frade P.¹, Tavares F.², Coelho A.², Delalibera M.¹, Correia A.¹, Presa J.¹, Barbosa A.^{1,3}, Matos A.²

¹NAEIL/Centro Bioética Faculdade Medicina Universidade de Lisboa, Lisboa, Portugal, ²Centro Hospitalar Lisboa Norte, EPE - Hospital de Santa Maria, Lisboa, Portugal, ³Faculdade de Psicologia da Universidade de Lisboa, Lisboa, Portugal

Objective: The aim of the study is to identify the existing human and technical resources providing bereavement support in palliative care units in Portugal.

Method: Nationwide, 49 palliative care teams were contacted by telephone, or via e-mail, between July and August 2012.

Results: Concerning the support given to bereaved families, only 8% of the teams reported not providing this service. The assistance to these families is provided mostly by psychologists, although nurses and social workers also offer this support. Most of the teams pay individual and family support and two teams also use group intervention methodology. The referral protocol for bereavement care covers several procedures: sending a letter of condolence (38.8%), telephone contact (59.2%), spontaneous demand (42.9%) and referral by health professionals (38.8%). Most palliative care teams assess the risk factors for grief complications with informal interviews. The evaluation of grief complications is also informal with the exception of five teams that use the Prolonged Grief Disorder Instrument (PG-13). Most professionals providing support have palliative care training or a basic education on grief and only 5 psychologists are currently undertaking specialized training on grief intervention. Only 48.8% of the teams have any kind of support for the health care professionals, which mostly consist of meetings to share and express feelings. More than half of the teams showed need and interest in a more structured support directed to the professional's grief.

Conclusions: Palliative care services in Portugal include bereavement support to families and professionals. However, the intervention protocol is mostly informal and there is a lack of assessment tools and specialized training on grief. This study contributes to the recognition of the existing resources and needs, from which could derive guidelines for the development of a more stringent procedure in grief assessment and intervention.

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Developments in Spiritual Care Education in German Speaking Countries