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MECC Workshop on Integrative Oncology in the Middle East

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A Collection of Abstracts

1. Integrative Oncology: A New Challenge to Middle Eastern Health Care Systems

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The incidence rates of cancer patients in the Middle East are on the rise; yet, measurable improvement in the quality of life for cancer patients need to be achieved and shown. For several cancers the disease is no longer a fatal one, but chronic and consequently quality of life issues rise to a significant level of importance and it is here that integrative oncology may play a major role. It is, therefore, foreseen that this new discipline will become a dominant factor in cancer care just as important as targeted therapies. Complementary and Alternative Medicines (CAM) therapies including mind-body measures and physical activities are currently implemented during active treatment to manage disease and treatment-related symptoms. It is time now to change the term CAM to Integrative Oncology. The main goal of implementing this new discipline to routine clinical practice is to improve the satisfaction of both the patient and the physician, in part by improving patient compliance with recommended therapies. In order to achieve this goal the patient's social history ought to be incorporated in his past medical history thereby understanding the patient's profile completely. With the increase of success rates in cancer treatments, the number of cancer survivors increases, and these patients continue to have needs dealing with both the acute and chronic effects of the cancer and its therapies for years to come. In this workshop discussions will revolve on: What can be done to assure that the patient will best tolerate the therapy, and what can be offered as best supportive therapy to treat the disease or the therapy-related symptoms.[1]

1. Rosenthal D.S. Integrative Oncology: The Future, in Integrative Oncology, Abrams D. & Weil A. Eds, Oxford University Press, 2009, pp. 571–581.

2. Narrative Medicine and Cancer Care

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Medicine is full of stories, about patients, about providers, and collaborative stories from both. Yet there is much to suggest that the patient's world and the provider's world remain far apart, and that efforts to bridge these two fall short. Patient-provider communication literature suggests that patient clues are not picked up by their caregivers, and the empathic opportunities often are not met with empathy even in situations of known cancer. The objective world view of medicine with its latest treatment technology and advances clashes with the more subjective, lived experience of illness.

There is increasing literature that calls for the integration of the patient narrative into care in multiple settings. The integration of patient narrative into cancer care at all stages of illness is getting increased attention. This literature is reviewed along with the communication and cancer literature that promotes the integration of patient desires, preference and values into their own care. In considering how to do this, the role of reflection as a method of learning in medical education and the outcomes of reflection are reviewed. The synthesis of these concepts results in a call for using narrative evidence in the effective delivery of care in order to improve patient care, enhance teamwork, and avoid burnout in medical professionals.

3. Using the Science and Application of Mind-Body Medicine to Prevent Stress and Burnout among Cancer Caregivers

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Healthcare Professionals working the in the field of oncology and cancer care encounter many stressors in their professional lives. These stressors include large patient case load; lack of training in coping with difficult patient situations; consistent exposure to pain, loss, and human suffering; and the lack of psychological support before and after the death of a patient. Operating under constant stress may cause healthcare professionals to experience professional burnout or to become physically or emotionally ill themselves.

Mind-Body Medicine Skills may be helpful in reducing stress levels, and in preventing and treating physical and emotional illness in healthcare professionals. A principle of

Mind-Body Medicine is that the physical, emotional, mental, social and spiritual aspects of one's life directly affect health and well-being. Furthermore, the mind-body connection can be accessed in a way that enhances each person's capacity for self-awareness and self-care. Mind-Body Medicine intervention strategies that have been shown to reinforce self-awareness and self-care and, thereby, promote health and well-being include meditation, imagery, autogentic training, biofeedback, journal writing, drawing, physical exercise, and group support.

Training healthcare professionals to integrate these skills into their personal and professional lives may reduce their stress through attenuation of stress hormone release from the hypothalamic-pituitary-adrenal axis and reduced activity of the sympathetic nervous system. In addition, these techniques have been shown to foster elements of emotional intelligence such as empathy and attention to feelings, which have been shown to lessen the probability of professional burnout or physical and emotional illness.

Conference attendees will participate in Mind-Body Medicine Skills Groups, where they will experience *Mindfulness and Body Awareness Meditations,* a variety of *Imageries, and Physical Movement* exercises to help reduce stress and enhance health and well-being.

4. Integrative Oncology: Definitions and State of the Art in the USA

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The use of complementary and alternative medicine (CAM) has increased dramatically in the past 10 years. Nowhere is this trend more apparent than when one examines CAM use by patients diagnosed with cancer. Usage rates have varied from 30–83%, with differences based mainly on definitions of CAM and type of cancer. Patients use complementary approaches for different reasons including increasing hope, improving quality of life, gaining a sense of control, or alleviating symptoms. Patients are often seeking a more holistic approach to managing and preventing disease, or do not totally accept allopathic practices for cultural reasons. This session will provide an overview and introduction to the area of CAM in oncology in the United States. Attention will be given to definitions, as this has led to confusion within the field. The M. D. Anderson's Integrative Medicine Program will be described as one particular model. The Integrative Medicine Program assists physicians and scientists to become more aware of and comfortable with CAM use among patients, increasing their knowledge of drug/herb interactions, and encouraging the incorporation of complementary therapies into conventional treatment pathways. We also have a clinical delivery center for complementary therapies. Clinical research efforts are conducted using the conventional approach to research-driven clinical care. Discussion of our ongoing research in mind-body therapies, acupuncture, and natural products research will be reviewed. At M.D. Anderson, integrative medicine is not a specific set of non-conventional treatment modalities, but rather an overall approach to treating cancer patients.

5. Integrative Approaches to Treating Anxiety and Insomnia

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The diagnosis and treatment of cancer are associated with distress and the fear of disease progression, recurrence, and death. The profound chronic stress that patients facing a life-threatening illness experience can often lead to mood disorders and sleep disturbances. At a global level, stress causes a chronic inflammatory response in our bodies. Chronic inflammation can potentially increase our vulnerability to and exacerbate chronic illnesses, such as cardiovascular disease, diabetes, gastrointestinal disorders, cancer, and other diseases in which we know inflammation plays a key role in etiology and progression. Stress also leads to poor sleep, increased health-impairing behaviors, (poor diet, lack of exercise, and substance abuse), vulnerability to mood disorders (anxiety and depression), inability to concentrate, increased negative social interactions, and other deleterious consequences. Such behavioral changes in turn influence our physiology and biology and create further damage to our bodies. Breaking the cycle of stress is critical to the health and well-being of society. This session will provide an overview of mood and sleep disorders in cancer. We will explore different integrative medicine treatments for managing these common side effects of cancer and its treatment including mind-body practices, acupuncture, and natural products.

6. Clinical Research in Cancer and CAM: What Are the Methodological Challenges, and How Can We Overcome Them?

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Modern cancer care is a complicated network of interventions delivered at different times and places with different intentions. There appears to be a gap between published studies showing little or no efficacy of CAM, and reports of clinical benefit from patients and CAM practitioners. This "gap" might be partially due to the current focus on placebo-controlled randomized trials, which are appropriately designed to answer questions about the efficacy and safety of pharmaceutical agents. In an attempt to fit this assessment strategy, complex CAM treatment approaches have been dissected into standardized and often simplified treatment methods, and outcomes have been limited. A different strategy for assessing CAM built on the acknowledgement of the inherent, unique aspects of CAM treatments and their regulatory status in most Western countries should include research on:

1. Context, paradigms, philosophical understanding and utilization
2. Safety status
3. Comparative effectiveness.
4. Component efficacy
5. Biological mechanisms.

Using the proposed strategy will generate evidence relevant to clinical practice, while acknowledging the absence of regulatory and financial gatekeepers for CAM. It will also emphasize the important but subtle differences between CAM and conventional medical practice.

7. Integrative Medicine in Pakistan

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Earliest practice of medicine was based on Hindu mythology what is now known as Ayurvedic system.

It was greatly influenced by Greek school and Muslim influence. Later the conventional medical system turned to be Indian medicine instead of Greek school of medicine. Lately British rule in India organized proper medical education. The orthodox school showed resistance to this change. Homeopathic medicine put forward by Dr Hahnemann enchanted Indian subcontinent too. A Romanian Dr John Martin Honigberger. was called in by the Maharaja Ranjit Singh, then ruler of Punjab province. Homeopathy gained acceptance due to little drug reaction and minimal cost suitable for majority of poor Indian public. After independence, Pakistan supported Homeopathy as well as Greek medicine or later called Islamic medical school. However the conventional medical System remained above all by the Government support. It was early 70's when Chinese medicine; viz., Acupuncture could win attention of the public with undeniable role of this 4000 years old system. Electroacupuncture in 1983 showed the efficacy of meridian diagnosis according to Dr Voll of Germany.

Anthraposophical medicine was introduced quite some time back for supportive care cancer cases. There was no such support available at that time; [late 70's] in Asia.

Recently Electro-meridian imaging is also gaining attention so as to depict meridian function graphically. Integrative medicine has been proving its worth despite people are facilitated by conventional school.

8. Improving Well-Being during Oncological Treatment

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The classical Homeopathy has promising role in handling the individual set of symptoms, if not the best, treating the whole man. Anthraposophical school claims to alleviate the toxicity and elevate the efficacy of chemotherapy thus shortening the duration of treatment course. Acupuncture and Acupressure are well claimed methods of symptom relief like pain and sometimes have proven even better than placing nerve blocks and has showen good control of chemotherapy induced nausea and vomiting. Mainly the major points to be utilised are stomach 36, spleen 6 and colon 4. For more impressive results, Auriclar points may also be used. Recently the use of software aided Electro meridian imaging has been giving better insight in the progress of working efficacy but this has yet to see the support of evidence based medicine. On the other hand in order to achieve mental stabilty of the patients highly depressed by holpessness and loathing of life can be handled by Relaxation therapy and Yoga, Eurythmy, using Biofeed-back, meditation through Alph wave technic (technique emerging in mid 90s), Nature study and other creative activities like music playing, model making, painting and self wiritng etc., to enhance form-giving forces thus possibly retarding metastasis. Aromatherpy, Hypnotherapy and massage therapy help to improve wellbeing, reduce generalised fatigue and check mood disturbances.

9. Complementary Therapies for Side Effects of Chemotherapy and Radiotherapy in the Upper Gastrointestinal System

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Introduction: Chemotherapy and radiotherapy remain the mainstay of treatment for patients with advanced malignant disease that is incurable by local surgery. However, effective use of these therapies is limited by toxic effects. Serious side effects in the upper GI system include mucositis, xerostomia, nausea and, vomiting. Standard of care for these side effects is suboptimal. Recent studies suggest Complementary and Alternative Medicine (CAM) may have a role in supportive care for people with cancer. We therefore reviewed the literature to assess the potential role of CAM in upper GI toxicities of chemo/radiotherapy.
Methods: We conducted a Medline search term combination for articles in English language that included: stomatitis, mucositis, xerostomia, nausea, vomiting, chemotherapy, radiotherapy, complimentary/alternative therapies, amino acids, antioxidants, vitamins, minerals, plant extracts, herbs, mind-body, guided imagery, hypnosis, acupuncture, massage and yoga.
Results: The initial search identified a total of 217 articles. Of these, 36 were selected and reviewed. Recommendations for integration of some CAM therapies in supportive cancer care can be made.
Conclusion: CAM therapies can be effective and safe in treating upper GI toxicities of chemo/radiotherapy. Guidelines in supportive cancer care should include appropriate CAM therapies, and patients need to be informed of such treatment options.

10. Integrative Medicine Role in Cancer Survivorship

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People do emerge from their encounter with cancer and go back to their regular lives after they finish the active treatment of surgery, radiation and chemotherapy. Up to 65 percent of adults that were diagnosed with cancer, and up to 92 percent of children, will live longer than 5 years after first being diagnosed with the disease. As a result, there are about 11 million survivors in United States, but most patients' live with the constant fear of the cancer coming back; they're mostly concerned with how they can prevent it from happening to them again. On the other hand, much of the physicians' attention is focused on researching ways to find the earliest signs of cancer when it returns, so that the disease can be diagnosed as early as possible. And that's certainly an important goal. But the bottom line is how can we prevent a recurrence and prolong survival-not just catching it early if it happens.

There is a growing body of research and clinical clues that suggest that some complementary approaches have potential to address this need. Patients don't want to just passively wait and do nothing, hoping they won't get sick again. What they want is more active options. Those active options include nutrition, nutritional supplements, mind-body interventions and other complementary medicine therapies. Those modalities have the potential to empower cancer survivors how to improve their wellness and quality of life after treatments, as well as touch the possibility of preventing recurrence of the disease.

11. European and Oriental Mistletoe: From Mythology to Contemporary Integrative Cancer Care

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Medical uses of European Mistletoe (*Viscum album* L.) and Oriental Mistletoe (*Viscum cruciatum* Sieb.) have been common since early times, included cancer therapy. The two mistletoes are mentioned in Classical sources (e.g. Dioscorides and Pliny) and by medieval European practitioners (e.g. Paracelsus) and Arab physicians (e.g. al-Kindi, al-Ghafiqi, and Ibn al-Baytar). These plants are also known as symbols of love and feature in legends throughout ancient and modern Europe. Contemporary traditional medicine uses of mistletoes are found in Lebanon, Israel, Egypt, Turkey, and Pakistan.

In 1916, Rudolf Steiner mentioned for the first time mistletoe extracts as possible for cancer therapy. *Viscum album* has gained notable attention due to its central role as leading remedy in cancer care in Anthroposophic medicine.

Contrary to the abundance of studies on *Viscum album*, there is lack of clinical trials concerning anti-cancer activities of *Viscum cruciatum*. We conclude a discrepancy between the paucity of research data concerning *Viscum cruciatum* and its attributed efficacy as suggested in historical and ethno-botanical literature. Thus, based on the significant findings achieved in *Viscum album* research, we recommend targeting research on the therapeutic potential of *Viscum cruciatum* in cancer care.

12. White-Berry Mistletoe (*Viscum album L.*) as Complementary Treatment in Cancer: Does It Help?

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The word 'mistletoe' is generally applied to plants with similar hemiparastic lifestyles and a certain degree of taxonomical relationship in three families (*Loranthaceae*, *Viscaceae* and *Eremolepidaceae*). The European white-berried mistletoe (*Viscum album L.*) has attracted special interest in folklore and medicine throughout the centuries. Mistletoe treatment for cancer was introduced in 1920 as part of the anthroposophical medical method. Today, mistletoe extracts are the most frequently prescribed unconventional cancer therapy in central European countries. Mistletoe extracts are complex multicomponent mixtures, containing various biologically-active substances such as glycoproteins, in particular the mistletoe lectins I, II and III, polypeptides (e.g. viscotoxins), peptides, amino acids, and oligo- and poly-saccharides. Furthermore, they contain innumerable enzymes, sulphurous compounds, fats, flavonoids, phenylpropanes, lignans, alkaloids and various other proteins. Numerous preclinical studies have reported immunostimulatory, cytotoxic and proapoptotic effects. In animal models, it can be said that mistletoe extract has direct antitumour activity as well as indirect activity through the immune system, and these studies provide a good base for clinical studies.

More than 20 prospective clinical trials using mistletoe extracts in patients with various malignancies have been reported. In most of these studies, the authors reported that mistletoe extracts had therapeutic benefit in terms of response rate, overall survival, quality of life and reduced side-effects. Unfortunately, most studies had at least one major weakness that questioned their reliability. Preparations are usually given as subcutaneous injections, and side effects are generally minimal.

13. Complementary Medicine Oncology Research in the Middle-East: Shifting from Traditional to Integrative Cancer Care

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Introduction: Complementary and alternative medicine (CAM) in the Middle-East is rooted in historical and traditional schools of medicine and is frequently used by patients with cancer. There is limited data on the extent of CAM research in Middle-Eastern countries regarding cancer care and potential benefits and risks of CAM modalities.
Methods and results: In this study, we searched the Medline database for studies in CAM and cancer care referenced by authors affiliated with Middle-Eastern academic institutions. We located 116 articles by authors active in12 countries. Research themes included CAM use in cancer care, aspects of doctor-patient communication in cancer care, studies of CAM education for health care providers, ethics and regulation, and CAM safety and quality assurance. Seventy-eight articles examined specific CAM modalities that include herbal medicine, Anthroposophic medicine, dietary and nutritional therapies, mind-body medicine, acupuncture, homeopathy, yoga, and Shiatsu. The majority of articles focused on various aspects of herbal medicine such as ethno-botanical surveys and reviews (7 articles), in-vitro studies (33), animal studies (8), and clinical studies (11).
Conclusions: The Middle East is a fertile arena for CAM research in cancer care. Collaborative research can significantly enrich the quality and impact of such research, based on sharing cultural and traditional knowledge

14. The Role of the Psychosocial Intervention in Reducing Patients Tension

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The main goal of this paper is to try showing the role of the psychosocial intervention in helping the Patients that suffering from threats diseases, Cancer as an example.

The psychosocial support today is considered as one of the main strategies that are used to strengthen the human being quality of life. Psychosocial intervention is a crucial component of holistic health care that aims to enhance the total health and high quality life.

It is found that the psychosocial support is not less important than the bio-physical interventions for patients who are suffering from life-threatening diseases.

Psychosocial support as a palliative care can reduce patients' tension when performing the necessary daily life activities, improve their capability in decision making, and increase their awareness of their active role in handling their own diseases. As examples of the psychosocial disorders that most likely terminally ill patients suffer from are phonic anxiety, depression, panic attacks, and fear from death.

This paper is not discussing the biomedical management but the main psychosocial interventions which can be summarized as follows:

1. *Emotional debriefing or psychological debriefing* is a one-time, semi-structured conversation with an individual who has just experienced a stressful or traumatic event.
2. *Virtual reality*: works by distracting the patient's attention from the pain and accompanying anxiety.
3. *The psycho spiritual approach:* This technique integrates both psychological growth and spiritual attunement, seeing therapy not as a 'cure to crisis,' but as a support for each one on their particular journey.
4. *Relaxation Techniques:* Progressive Muscle Relaxation - this is a technique for achieving a state of deep relaxation. You tense and then relax each muscle group working from your head down to your toes, whilst sitting or lying in a comfortable position, other techniques may used like: breath focus, body scan, relaxation music, meditation.

15. Herbal Medicines in Cancer Care in the Palestinian Authority

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Little is known about the use of herbal medicines in cancer care in the Palestinian Authority, PA. This review aimed to identify the plants used by people in cancer care in the PA, and their attitudes towards herbal remedies. All ethnobotanic studies carried out in the PA and identified as relevant to the purpose of the review were assessed. These studies involved 1061 informants and were mainly aimed at studying the current status of the Traditional Arabic Palestinian Herbal Medicine, TAPHM in the PA, and determining medicinal plants still in use and their primary health care importance at the household level, economic value, conservation status, and their healing potentials.

Many plant species (349 species of which 345 in the West Bank, and 120 in Gaza Strip), were reported to be still in use in TAPHM for treating various human ailments including cancer. Eighty one of these plants were reported to be used for cancer care (West Bank 76, and Gaza 18). The top five species used for the treatment of cancer are: *Arum palaestinum, Urtica pilulifera, Allium sativum, Olea europaea, Nigella ciliaris,* and *Allium cepa.* However, information on self-medication with herbal remedies among PA populations living with cancer is lacking. Exploring cancer patients' information needs and preferences, will assist in the development of a suitable resource for both the patients and the professionals advising them.

16. The State of Traditional Arabic Palestinian Herbal Medicine (TAPHM) in the Palestinian Authority (West Bank and Gaza Strip)

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An ethnobotanical study on medicinal plants was carried out over the period 2004–2007 in the Palestinian Authority (the West Bank and the Gaza Strip). The study population comprised 735 informants (healers, attareen, and people known in their communities to be knowledgeable in traditional

medicine) (582 in the West Bank, and 153 in Gaza). A semistructured questionnaire was employed to collect ethnobotanic information.

Many plant species (288 species of which 279 in the West Bank, and 120 in the Gaza Strip, belonging to 90 families and 241 genera), are still in use in traditional medicine in the Palestinian communities, for treating various human diseases. Of 279 plants mentioned by the informants in the West Bank, 211 (75,6 %) were mentioned by $\geq$ three informants. Of the 120 plant species mentioned in the Gaza Strip, 83 (69.2%) were mentioned by three or more informant. On the basis of their primary uses, 56 of these plants were reported to relieve gastric disorders, 33 for skin disorders, in the West Bank, while in the Gaza strip, 10 were reported to relieve respiratory and urinary systems disorders. Indices on fidelity levels (FLs), relative popularity level (RPL), and rank-order priority (ROP) were calculated for the plants mentioned by $\geq$ three informants. Plants were classified in two groups: 'popular' (RPL = 1) or 'unpopular' (RPL < 1).

17. Validation of the Arabic Version of the M.D. Anderson Symptom Inventory (MDASI-A)

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Objective: The goal of this study was to demonstrate the validity and reliability of an Arabic version of the M.D. Anderson Symptom Inventory (MDASI-A), a multi-symptom assessment tool for use with cancer patients, and to describe symptoms related to cancer and its treatment in patients being evaluated at a major cancer center in Morocco.
Methods: The MDASI-A was developed using forward-backward translation method, with collaboration between health professionals, Arab country native and English fluent bilingual translators, and cancer patients at The University of Texas M. D. Anderson Cancer Center in Houston. We enrolled 165 Arabic speaking patients with different types of cancer, who have undergone various treatments, and who have different levels of severity of pain and other symptoms.
Results: In the Moroccan patient sample, the majority of patients (68%) had advanced cancers. The average age was 49 (+/−14) years of age. Among this sample, 82% were Arab White, 18% of sub-Saharan African descent, 56% were female, 95% were educated below a high school level, and only 4% were employed at the time of survey. Breast, GI, lung and gynecologic cancers affected about 68% of the patients. Sixty-two percent of sample had an ECOG performance at grade 3 or 4. Cancer-specific treatments were being given to 24% of these patients, with 8%, and 14% of the sample undergoing chemo and radiation therapy respectively in the month preceding their enrollment in the study. In a forced 2-factor solution for the 13 items factor analysis, there was a general symptom factor and a GI factor as seen in other language MDASI validation studies. Results of the significant correlation between the MDASI-A summary scores for the symptom and interference subscales and ECOG 0 to 4 grades ($P < 0.001$) provided a good indication of concurrent validity of the MDASI-A. Significant differences in overall mean symptom severity and interference by independent sample and Mann-Whitney t-tests between patients with poor (grades 0 to 2) and those with good (grades 3 to 4) ECOG performance status ($P < 0.01$) demonstrated the known-group validity. Internal consistency was satisfied for the MDASI-A. Alpha values were 0.85 for the 19 total items, and 0.78 and 0.79 for the symptom and interference subscales. The most severe symptoms were pain, fatigue, poor appetite, sadness, sleeping disturbance, shortness of breath and distress. Patient-reported fatigue, sadness, numbness, and poor appetite were most predictive of the average interference with patient's daily life ($R^2 = 0.45$).
Conclusion: An Arabic version of the MDASI is a valid and reliable patient reported outcome instrument, which can be used to evaluate patients' multiple symptoms in the clinical practice for symptom management or in clinical research among Arabic speaking cancer patients in Morocco.

18. Integrative Paediatric Cancer Care: Challenges of CAM Integration Perspectives from an Integrative Paediatric Cancer Centre

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Complementary and alternative medicine (CAM) is used in general paediatrics as well as in paediatric oncology. CAM-use-rates vary – depending from the population studied – from 15% up to more than 50%. Most CAM-therapies take place on demand of the parents. Some paediatric oncology centres (POC) may offer some kind of CAM as supplemental therapy (e.g. mind-body therapies like massage) but to our knowledge there are no POC really integrating CAM into clinical daily-life-care.

We report about our own 40-years experience, integrating CAM (especially therapies according to Anthroposophic Medicine) into conventional cancer-treatment in children. Our POC is part of nearly all actual clinical trials in Paediatric Oncology in Germany. Conventional therapies (chemotherapy, radiation therapy, surgery) are completed with complementary therapies including mistletoe.-therapy, other anthroposophic and homeopathic remedies, mind-body therapies (e.g. rhythmical massage, compresses, eurythmy therapy), art-therapies and special aspects of daily-life-design. Practical aspects of integrative paediatric oncology are highlighted and discussed.

Above that we report the results of a patient-satisfaction-survey witch is done every two years and that shows, that in most categories the patients/parents are more satisfied from integrative paediatric care than from conventional paediatric care alone (local and national benchmark).

19. Palliative Care in Terminal Cancer and AIDS Patients in the Middle East and Africa

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Malnutrition will be present due to cancer anorexia and cachexia (CAC) are present in all cases of advanced cancer. Other factors are also present such as nausea, vomiting, mal digestion, absorption, mechanical obstruction (tongue, esophagus), chronic bowel obstruction, NSAINDs, Chemotherapy, pain, anxiety, depression and lack of sleep.

Some reactions in the form of release of pro inflammatory cytokines (Tumor necrosis factor, Interleukin –1, interferon and tumor –driven catabolic factors. This will end by severe tissue catabolism and loss of total body mass.

Treatment of (CAC) by Anticytokines agents, they may act by down-regulating the synthesis and release of pro inflammatory cytokines. On the other hand Improvement of the appetite by anti-seretonergic drugs, increased gastric motility and ß$_2$-agonists, anabolic agents. Other lines of treatment would be by antioxidants and parentral replacement therapy but with limited response.

Attention to relief pain of the primary cancer is of great importance.

All these measures are to be used as a trail to improve the quality of life but not to prolong the life span.

20. Integrative Approach for Cancer Pain Management

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The prevalence of pain in cancer patients has been reported to be between 50% and 70% and 65% for advanced cancer. For cancer patients, the choice of pain relieving drugs is limited. Generalised medications for pain relief can interfere with cancer medications, thus limiting their use. In addition, some patients are either reluctant or unwilling to take further medications or are unable to tolerate the side effects. The net result of these complications is that many cancer patients receive insufficient pain management therapy.

Scientists have known for many years that pain is modulated on many levels before it is experienced. It is well understood that pain is a multifaceted phenomena, with biological, emotional, social, spiritual and psychological aspects.

Modern thinking accepts that pain is inseparable from emotions and pain can exist even without any tissue damage. This approach is based on a landmark theory called the "Gate Theory" (Melzack R, Wall P. Pain Mechanisms: A new theory. Science 1965; 50: 156–161).

The importance of Gate Theory n the treatment of cancer patients is that descending cortical inputs that affect pain perception include psychological variants such as belief about pain, emotions, reactions to stress and thoughts.

Interventions that target malfunction of thought, belief, emotions and stress can change pain perception and thus the experience of pain itself.

Cancer patients use a range of complementary modalities for the management of pain. For some of these modalities there is either scientific evidence or promising preliminary results for their role in pain management. Some are deemed to be safe non invasive and relatively free from toxicity.

Approaches such as acupuncture, massage and mind-body interventions, have been shown to reduce pain and enhance quality of life. It should be noted that not all complementary therapies are appropriate for, or useful to cancer patients. Even helpful complementary modalities may not be optimal under some circumstances.

For example, some botanical products and dietary supplements are not recommended during chemotherapy, radiation, or when surgery is planned, as they can interfere with prescription medication and adversely affect the efficacy of some chemotherapy drugs.

The goal of cancer pain management is more than just the reliving of pain; it is the maintenance of normal quality of life and overall sense of well being. The best way to achieve this is through an integrative approach where complementary modalities work side-by-side with mainstream medicine.

The presentation will summarize the overall modalities of cancer pain management with special focusing on non pharmacological, psychological and complementary methods regarding their efficacy, methods of use, precautions and side effects.

21. Folk Medicine in Egypt: Past and Present

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Egypt folk medicine came mainly from medical scrolls found 1550 BC and from designs and descriptions found on the walls of temples. Sanctuaries and temple priests had possessed high power since medical treatments were highly integrated with religion. In present time, folk medicine is still in use and its economic potential is expanding in Egypt. Depending on its increased popularity where the plant kingdom is the main source of its material, it is however regarded as market-driven goal. Recently, private sector in cooperation with Europe, i.e. SEKEM Co. had developed the cultivation of these plants for local consumers and for export in organic farms in Delta. In the oases of Egypt, palm dates' different processed parts which contain boron, florin, vitamin B2, vitamin A, niacin and iron are extensively employed in folk medicine by the Bedouins; in the remedy of rheumatics, in teeth and skin healing and protection and in treating those who suffer from anemia. Another very interesting example could be the inexpensive fenugreek plant "*Greek hay*" which its seeds were found in Tutankhamun's tomb.It is considered in folk medicine to bear a transcending boundaries between magic/religious and medicine. The juice of the boiled seeds is taken even in modern Egyptian culture as a must to increase mother's milk while nursing whereas, sprinkling its seeds will enhance a family fortune. In addition it is said that its oil is having a strong reputation to transform an old man into a young one.

22. Studies on Medicinal Plants of Potential Use in Egypt

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Research activities take place in the National Research Centre of Egypt on medicinal plants that started 1963 had taken folk medicine as a base for the studies. We mainly aim to establish methods/treatments to increase the metabolites from which target active constituents originate in plant tissues/cells/organs, to statistically significant levels. In addition to morphological measurements, photosynthetic pigments, phenolics, alkaloids, terpenoids and glycosides are estimated using spectrophotometer, GLC and/or HPLC. As an example, visnagin and khillin of *Ami visnaga* L and hyoscyamine and hyoscine in *Hyoscyamus muticus* L. were remarkably increased due to spraying the plants with thiamine and a cytokinin respectively. The studies are then developed to include plants with special reference to their potential in cancer care research. However, the foliar spray of bezyl adenine in *Majorana hortensis* L resulted in significant increases in the terpenes "terpene-4-ol and linalool". Other plants under investigation are *Citrillus colosynthesis* L. *and Fagonia* spp. Recently research attempts in stimulating the production of vinblastine and vincristine in *Catharanthus roseus* L. via gene manipulation and tissue culture methods are introduced.In parallel, we apply anatomical and histochemical tests using light-stain-reaction technique under the epifluorescent microscope.From such a test we are able to detect and localize certain chemical formula(s) relevant to their possible role in anti tumor research in a given plant/tissues' structure.

23. Problems Facing the Clinical Pharmacist

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As an inpatient clinical pharmacist, my duties were as follows: revising patients file for present and past history, reason of admission, medication history, proposed treatment plan, lab results. Attending physician round and ensuring that the prescribed protocol is the most appropriate for each patients according to hospital policy, diagnosis, patient condition and lab results. Calculating doses of chemotherapeutic agents, antibiotics, and other supplementary medicines patient is receiving. Checking for possible drug interaction with other drugs and food. Entering chemotherapy and antibiotic preparation orders to the IV admixture area. Supervising chemotherapy administration (cleanliness of the venous access, proper rate of infusion, absence of air bubbles and purity and use of aseptic technique). Educating nursing staff regarding medication handling, administration, rate and aseptic precaution. Educating the patient and his family about the disease, medication, do's and don'ts

Problems Encountered

Insufficient pharmacy staff members
Pharmacist is responsible for too many patients
Deficiency in some needed medication
Difficulty of ensuring proper hygienic measures (too many patients per room)
Infection control problems
Discharging of patients without pharmacy consultation so patients do not receive full instruction about medication to be received at home and the possible side effects and how to deal with them.

24. The Effect of Progressive Muscle Relaxation and Guided Imagery in Improving Psychological Wellbeing and Quality-of-Life for Breast and Prostate Cancer Patients: A Randomized Controlled Trial

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Introduction: This study aimed to determine whether relaxation and guided imagery techniques have the potential to reduce anxiety, depression, pain intensity and improve Quality-of-Life for prostate and breast cancer patients.
Material-Method: Two-hundred patients with breast and prostate cancer were randomly allocated to either the study group ($n = 100$) or the control group ($n = 100$). Only patients in the study group received relaxation and guided imagery sessions. Each participant received 4 sessions of relaxation followed by guided imagery. Saliva was collected before and after the sessions and analyzed. Other measurements included assessment of Quality-of-Life (EORTC QLQ C30-Breast Module-BR23, Prostate Module-PR25), pain intensity (pain intensity rating scale), depression (Beck Depression Inventory) and anxiety (Self-Rating Anxiety Scale-SAS).
Results and discussion: Even though the study has not yet been completed initial results show that the amylase level was significantly decreased after the relaxation and guided imagery sessions to the study group compared to the control group. Quality-of-Life, anxiety, depression and pain ratings also show a positive response to the interventions.
Conclusion: Salivary α-amylase levels were significantly reduced and reacted more rapidly than cortisol levels to the interventions, suggesting that it is a better relaxation index. The use of Mind-Body techniques appears effective in reducing the levels of anxiety, depression and body discomfort in patients who have breast or prostate cancer. These simple and inexpensive interventions enhanced the psychological and physical wellness in these patients.

25. The Role of the Counseling Psychologist in Cyprus

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My role is that of a Counselling Psychologist at the Association of Cancer Patients and Friends. My job includes working on a one-to-one basis and in group settings with people who have or have had cancer, as well as working with their close family members.

Clients are referred to me during all the stages of the cancer experience – either prior to them knowing their diagnosis, at diagnosis, during active treatment, at remission, at recurrence or at palliative care stage.

What I find particularly challenging within my job setting is the volume of referrals that I may have during particular time periods, the demands that clients may have in regards to having an immediate appointment and the lack of certain evaluation guidelines or procedures prior to referral. Focusing on the latter, it is my experience that I often receive referrals

from within and from outside my immediate team for clients who do not necessarily need to see a psychologist, namely, clients who could benefit just the same with speaking to a social worker, support worker or even a trained volunteer.

It is my opinion that if we were to invest time in recruiting, training and supporting volunteers who have a genuine interest in helping clients, as professionals we could provide even better quality care for individuals who face more complex challenges such as difficulties with illness adaptation and maladaptive coping mechanisms, anxiety, depression – psychological challenges where our therapeutic skills and knowledge as psychologists can be of greater use and benefit.

26. Getting the Hospice Message Across

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Palliative care is a recognised medical speciality. As the Hospice Sister at The Friends' Hospice in Paphos the role requires direct responsibility for the deliverance of palliative nursing to patients. To achieve significant results and outcomes in palliative nursing it is crucial to work within a framework incorporating a multi- disciplinary team of practitioners.

Within this framework, patient care is discussed, planned and implemented with a continual evaluation and assessment of the patients' needs. Modifications to care incorporate giving consideration to the "whole patient" taking into account their physical, psychological, spiritual and emotional needs.

Palliative care in a Hospice setting is a relatively new concept within the Paphos Region. The palliative care team face daily challenges to "get the message across" regarding the concept of a Hospice. It cannot be argued that an essential prerequisite to deliverance of quality palliative care is communication, education and awareness. Culturally, this provision has not previously been available in Paphos and so the Hospice has embarked on a communication programme to ensure that the work of the Hospice expands to enhance in-patient palliative services for patients with life limiting illnesses.

To increase awareness, through communication, it is proposed to:-

- Maintain and foster relationships with the medical services, state and privately owned organisations.
- Facilitate and promote media coverage within the multicultural society
- Extend the availability of psychosocial needs for patients and relatives.
- Improve the availability of information within the community.
- Continue to extend the dialogue with various agencies.

27. The Cyprus Association of Cancer Patients and Friends

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The Cyprus Association of Cancer Patients and Friends (PASYKAF) is a standalone home care service offering care to cancer patients over the age of 16 y in their home. This care is offered by a full multidisciplinary team to patients and their families from the time of diagnosis and all the way through the disease progression, allowing them the opportunity to die at home if they so wish.

The service is unfortunately only available in the day from 7 am to 6 pm and thus many nurses have become volunteers, working out of hours offering their time and services to patients who are dying at home. In the short term this may be a viable solution as the founding nurses are very passionate about the work they do and feel they cannot abandon people at the end of life. In the long term though as a manager this is unacceptable, nurse's burn out and new nurses coming into the service have limits and boundaries. The main problems with opening the hours are funding and nursing shortages.

PASYKAF offers a free service including transportation to the oncology hospitals from the outlying villages and loans equipment in the home. The organization collects donations and fundraisers to continue offering its services including buying its own medical supplies like syringes, sharps bins catheters etc.

In order for a service like this to grow and develop it requires stable funding and some input from government.

At present in Cyprus we have no palliative legislation or recognition of palliative care specialty. Currently no guideline or standard of care exists for services to be evaluated by. The Cyprus government has recently published a National cancer strategy incorporating within this plan palliative care as one of the arms. We await a task force to be chosen in order to begin the first steps into integrating palliative care into the national health care plan that Cyprus is building. This task force, if operates effectively will be able to look at many issues that affect care. Out of hours emergency drugs, drugs not available in the country to effectively manage symptoms at the end of life, 24 hr home care service and Palliative care doctors available in all the major government hospitals, so that patients being cared for in the community have access through an integrated system with continuity of care between hospital hospice and home.

28. The Pancyprian Association of Cancer Patients and Friends (PASYKAF)

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PASYKAF is an NGO which offers both supportive and palliative care to cancer patients in Cyprus. This registered charity was founded in 1986 by a group of people who saw the urgent need for support to patients and their families.

Today our staff totals over 50 and is divided into five multidisciplinary teams which are located in the main towns of southern Cyprus and which support patients from initial diagnosis through to end of life.

Emphasis is placed upon teamwork, including the careers and ensuring that the patient is the epicenter of that team. Good communication and continuing staff education are of paramount importance in helping us to strive towards our vision of offering best quality care to our patients and their families.

One of the main obstacles in offering such care is our current inability to provide a 24 hour service. Lack of funds and a general shortage of nurses have made this impossible to date.

Whilst there are two palliative homecare charities which share a similar vision but vie for funds, staff and recognition we will continue to struggle. In combining forces both organizations could present a united front in order to adopt standards, pathways and guidelines, whilst at the same time promoting a safer environment, enhancing staff education, helping to decrease unnecessary hospital admissions and supporting patients' rights to "live well and die well."[1]

29. The Children's Clinic for Integrative Medicine in Amsterdam

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In this lecture we describe an example of the successful implementation of CAM and IM in pediatrics. In 2003 a pediatric integrative medicine clinic was established in the Slotervaart Hospital, a Dutch teaching hospital. The clinic provides advice and treatment to inpatient and outpatient children in a shared care model with complementary therapists. The clinic also provides a limited range of evidence-based complementary modalities for inpatient children, aimed at symptom control and decreasing pain and stress.

The clinic was set up through the special interest of the head of the pediatric department gathering support from her fellow pediatricians, other medical specialists, nursing and other staff, and the hospital board members. A shared care model with complementary therapists was developed for the outpatient population.

Currently the clinic is run by the pediatricians, who have been trained in several complementary modalities, and a group of carefully selected and licensed naturopathic and ayurvedic practitioners, hypno- and massage therapists, homeopaths, osteopaths, acupuncturists and integrative psychology counsellors. There is a close collaboration with the medical librarian who maintains a database of integrative medicine literature and provides up to date evidence-based literature on specific integrative medicine topics on a regular basis.

The clinic enjoys a special position in the Dutch health care system facing specific and unique challenges.

Since its inception, the integrative therapies program has been offering a triad of services to children with chronic diseases and cancer. As part of our education initiatives two websites were established to disseminate reliable information on IM to families as well as the health care providers involved in their care.

30. Integrative Oncology - Indian Perspective

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About 2.4 million Indians live with cancer. Optimal definitive treatment reaches a small minority. Most go through the agonizing experience of choosing between modern medicine and several alternative systems of medicine. Practitioners of Modern Medicine are often accused of a totally "disease-oriented approach" without consideration for the well-being of the patient and family. Such an approach can cause the following problems in developing countries:

- Cost of treatment causes families to fall into a debt trap. Often treatment is abandoned half-way through because of cost.
- Psychological and spiritual issues are ignored leaving patients emotional wrecks.
- Social problems cause destruction of the family – often involving the next generation.

Many patients opt for alternative systems of medicine, often hopping from one to another, adding to the psycho-socio-spiritual issues. This *system-shopping* appears to prevent a state of acceptance and contributes to financial burden.

The palliative care movement in India has brought a change into the scene – offering some degree of holistic approach with support of the community, incorporating psycho-socio-spiritual care. But it reaches too few and too late. And it has been able to offer very little by way of integrating various systems of complementary medicine. It has generally permitted patients and families complementary strategies alongside palliative care; but has not been able to incorporate most of them as part of routine care. Till scientific evaluation of various systems of medicine becomes a reality, truly integrative medical practice will remain a distant dream.

31. Nutrition and Cancer: Why Are These Topics Important?

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Loss and weight and appetite are two of the most common symptoms and signs in patients with advanced cancer. At the end of life, the majority of patients suffers from this symptom complex. Yet, there is much we do not know about its management. In patients with severe weight loss and potentially curable disease, a role might exist for aggressive nutritional support. For most patients, however, when the cancer is more advanced, aggressive feeding may in fact be detrimental. A more palliative approach might be more preferable. This talk describes some of the challenges in managing patients with advanced cancer, underscoring some of the limitations of pharmacologic therapy and some of the pitfalls in conducting research in this area.

32. How Much are Cancer Patients Paying for Complementary and Alternative Medicine?

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[1]Amass C. The gold standards framework for palliative care in the community. The Pharmaceutical J. 2006; 276:353–54

Put simply: billions of dollars a year. However, the question is far more complicated, and the answer requires more than a dollar amount. In discussing this question, others arise. Are patients truly paying for therapy that is tangibly helpful? Who actually pays these costs: the patient or a third-party payor? Despite the large dollar amount described above, is complementary and alternative medicine ever cost effective? This talk begins to explore the answers to the questions posed above.

33. Community Palliative Care Nursing – The Cypriot Experience

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Working for the past 15 years, with PASYKAF, as a community palliative care nurse, dealing with patients at any stage of their cancer diagnosis, I have observed many developments towards a better, and fairer healthcare system in Cyprus.

A state funded district nursing service has been piloted in the main towns and recently implemented in the authors area of work, this will hopefully, start to allow the PASYKAF homecare team to concentrate more on best supportive, palliative care as our services are often overstretched and requested by patients who do not fit our criteria. This is a positive move which requires good communication between this public funded service and the NGO thus promoting an environment of close cooperation as the fair provision of a high standard of healthcare is paramount.

As ever there is always a downside.

- Lack of choice of place of care.
- Fragmented care.
- Lack of co-operation between different departments and health care professionals.
- Lack of carer support.

The above list highlights some of the problems encountered regularly within the field of palliative care(1). Cyprus is not alone, and may even be in a better position at this point to benefit and learn from the experience gained abroad in this speciality.

Clinical governance has been defined as "corporate accountability for clinical performance (2)." Within the author's work environment, more clinical standards and guidelines need to be set in place, thus encouraging ongoing audit, enabling measurement of the actual standards of care offered.

It is only when we know what we have accomplished that we can consider how to improve our services and continue striving towards PASYKAF's ultimate goal of improving patient quality of life.

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34. Challenges Facing the Psychologist in Cancer Care

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My job as a psychologist is to give support and counseling to cancer patients and families and help them adapt to living with cancer and accept this new reality. A big problem but at the same time a big challenge for me is when I have to deal with co- morbidity issues. Some of our cancer patients have had psychological disorders such as anxiety, mood and personality disorders for most of their lives, even years before they get cancer. In those situations it is difficult to distinguish whether cancer itself or other issues in the past are responsible for the current depression or anxiety. Furthermore, very often it is difficult to distinguish whether a psychological symptom is really due to psychological distress, due to medication site effects or due to the illness itself. Such symptoms are loss of energy, sleep disturbance, fatigue, poor appetite, low sex drive, psychomotor retardation etc. What we can do in such situations is to be cautious and not to jump to quick conclusion. It is important to have in mind that things are not always black or white but there is gray as well. So, we need to be patient with our patients and get enough information about them in order to have a global, comprehensive picture about their situation.

Another challenge for me is when I get into those deep discussions about life and death, meaning of life etc with some of my patients. That's sounds such a difficult thing but at the same time it is very therapeutic for me as well. Talking about death can help people appreciate life more and be able to live in "here and now" and enjoy the present.

35. Palliative Care Development In Georgia

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Realization of the Palliative Care in Georgia was started about ten years ago with significant successful steps taken during last period, which is confirmed by following:

- Existence of educational-methodical material of "Palliative Care" in Georgian Language;
- Initiation of educational course of "Palliative Care" in Medical Universities and Colleges;
- Existence of accredited course of Continued Medical Education of doctors in Palliative care;
- Organization of Hospice and Palliative Care Service at the National Cancer Center and financial support from Governmental budget;
- Organization of mobile teams providing home-based Palliative Care financial support from Governmental budget;
- Establishment of office of National Program coordinator of "Palliative care" at the Parliament in Georgia;
- Approve by Parliament of Georgia amendments in 4 laws of Georgia: 1)Law of Healthcare, 2) Law of medical activity, 3) Law of patient's right, 4) Law of concerning

the narcotics, psychotropic materials, precursors and narcological aid.

Currently, according to the Georgian Law of "Health Care" Palliative Care (PC) is non separated part of continuing Medical Aid.

Georgian National Palliative care Association and Palliative Care National Coordinator at the Parliament of Georgia arranged the National Plan of Palliative Care for next five years (2011–2015) which is already approved by Health Care Commute of Parliament.

Due to successful steps and achievements the main challenges on the way of PC development are:

a) Lack of adequate information among the society (customers) as well as potential stakeholders and decision-makers; b) Lack of knowledge among healthcare professionals; c) Lack of funding.

Abstract Author Index

by abstract number