multi-disciplinary team and collaborate on a very high level in the care of pediatric patients. Such a collaborative setting is possible because the work of OA is structured around three principles: Innovative, practical and theoretical integration and ongoing training and quality assessment of the volunteer patient and family support from Oscar’s Angels volunteers throughout the care pathway Government certification, institutional representation and active collaboration in educating healthcare professionals about the importance of involved patients’ needs. Operating in France since 2021 (with more than 600 and 200 families respectively supported last year), the OA volunteering program is specifically tailored to the needs and demands of hospitals and families. It can therefore be successfully reproduced in many settings. OAs services come at no cost to hospitals. This is particularly important for implementing the program in developing countries where healthcare resources are extremely limited. But it is also relevant in developed countries as well where healthcare budgets are under strain. In 2020 an informal internal OA survey highlighted that the patients’ families/volunteer/healthcare professional interface provides added value for all of the stakeholders. A formal survey will be conducted in 2022 to corroborate these results.

SWK-02. PALLIATIVE SEDATION IN PEDIATRIC PATIENTS SUFFERING FROM BRAIN TUMORS: CHOOSING THE BEST DRUGS TO IMPROVE END OF LIFE
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INTRODUCTION: For terminally-ill children with brain tumors care focuses on quality of life, and patient management fundamentally affects grieving families. We describe our experience of palliative sedation (PS) for children with refractory symptoms caused by solid tumors, focusing on BT (brain tumor). METHODS: Retrospective data on all children treated for BT and died between 1/2016-12/2020 in our Institution were collected. RESULTS: Of the 29 parents eligible for the study, M/F 17/12, the median duration of disease was 12.5 months (range 3-51) and the median age at death was 8.5 years (range 1-22). Fifteen had BT (5 DPB, 2 Ependymoma, 8 high-grade glioma). The reasons for starting PS in BT were: seizure(s) (5), central respiratory failure (6), locked-in-syndrome (1), decerebration (1). Midazolam was combined in 16 cases with other drugs (neuroleptics, alpha-2 agonists, antihistamines) to achieve adequate sedation. Ten/15 with BT received antiepileptic therapy, apart midazolam. BT patients received oral benzodiazepines before PS less frequently than those with other cancers (p < 0.0033). Throughout the period of PS and on the day of death, patients with BT were given lower doses of midazolam and morphine, Mean dose of midazolam was 0.027 mg/kg/h (range 0.0069-0.06) for patients with BT, 0.055 mg/kg/h (range 0.01-0.38) for the others, while the mean morphine doses were 0.048 mg/kg/h (range 0-0.08) and 0.09 mg/kg/h (range 0.013-0.13), respectively. CONCLUSIONS: BT patients require less medications and antiepileptic therapies because brain tumors impair the level of consciousness. Optimizing pharmacological treatments demands a medical team that knows how drugs (even developed for other indications) work. Emotional-relational aspects are important too, any action to lower a patient’s comfort or consciousness should be explained to the family. Guidelines on PS in pediatrics could help, providing they acknowledge that any child’s death is always a unique case.

SWK-03. NEUROIMAGING IN CNS TUMOURS: TO GA, OR NOT TO GA, THAT IS THE QUESTION.
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Children with a Central Nervous System (CNS) tumour have frequent magnetic resonance imaging (MRI) scans during their disease trajectory. Younger children have these performed under general anaesthetic (GA). A potential initial and ongoing treatment for young children with BT, 0.055 mg/kg/h (range 0.01-0.38) for the others, while the BT patients received antiepileptic therapy, apart midazolam. BT patients received oral benzodiazepines before PS less frequently than those with other cancers (p < 0.0033). Throughout the period of PS and on the day of death, patients with BT were given lower doses of midazolam and morphine, Mean dose of midazolam was 0.027 mg/kg/h (range 0.0069-0.06) for patients with BT, 0.055 mg/kg/h (range 0.01-0.38) for the others, while the mean morphine doses were 0.048 mg/kg/h (range 0-0.08) and 0.09 mg/kg/h (range 0.013-0.13), respectively. CONCLUSIONS: BT patients require less medications and antiepileptic therapies because brain tumors impair the level of consciousness. Optimizing pharmacological treatments demands a medical team that knows how drugs (even developed for other indications) work. Emotional-relational aspects are important too, any action to lower a patient’s comfort or consciousness should be explained to the family. Guidelines on PS in pediatrics could help, providing they acknowledge that any child’s death is always a unique case.

SWK-04. INVESTIGATION ON ANXIETY AND DEPRESSION OF PARENTS OF CHILDREN WITH CENTRAL NERVOUS SYSTEM TUMORS
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OBJECTIVE: Family members of children with Central Nervous System (CNS) tumors are often accompanied by anxiety, depression and other adverse emotions, which have a great impact on the quality of life of children. This study aims to investigate the incidence of anxiety and depression in parents of children with CNS tumors. METHODS: One of the parents of 165 children with CNS tumors who were hospitalized in Guangdong Sanjgu Brain Hospital from January 2021 to December 2021 were evaluated for anxiety and depression by SAS and SDS. RESULTS: 100 (60.61%, 100/165) had anxiety, and the anxiety score was statistically significant (P < 0.01) with the normal Chinese population (29.78 ± 10.01) (P < 0.01). 100 persons (60.61%, 100/165) had depression, and the depression score of the cohort was (55.02 ± 9.98), higher than that of the normal population (33.46, 8.55), with statistical significance (P < 0.01). CONCLUSION: The parents of children with CNS tumor are the high risk group of anxiety and depression, which should arouse more clinical attention.

SWK-05. CLINICAL SOCIAL WORK IN PEDIATRIC NEURO-ONCOLOGY – A RESEARCH PROJECT ON THE SOCIAL DIMENSION USING SOCIAL DIAGNOSTICS
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PURPOSE: A neuro-oncological disease of a child represents a high psychosocial burden for the child and their families focusing on medical, psychological and social care is significant in the course of the disease. Studies show that existential problems or lack of social support are risk factors. Therefore, this research investigates the impact of a pediatric neuro-oncological disease on the social dimension using a standardized social assessment. RESEARCH DESIGN: The project is based on a retrospective cross-sectional study (04/2015-12/2021) including consecutive patients with high- or low-grade gliomas at the Medical University of Vienna - Department of Pediatrics (n= 160). By using a specialized and standardized social diagnostic tool (DISAPO) starting at the onset of disease, the clinical social worker surveys the social situation (social network, work situation, financial and housing situation, legal status, insurance status, etc.) with the parents. Based on the assessed social situation the clinical social work interventions (CSWI) are recorded throughout the child’s treatment. The results are statistically evaluated including medical data. RESULTS: The results in the DISAPO showed that in one or more areas of the social dimension: disease-related interventions: 100%, work intervention: 80.6% (n=129), living situation: 43.8% (n=70), social support: 59.4% (n=63), socioeconomic interventions: 19.4% (n=31), residence and travel: 8.8% (n=30). CONCLUSION: These results emphasize that in case of a pediatric neuro-oncological disease the social dimension is always affected and comprehensive CSWI are highly needed. For a holistic care of the patients and their families a biospsychosocial standard of care including all professions is indispensable. In addition, a standardized approach for assessment and intervention showed that needs could be assessed more adequately and interventions more targeted.
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PURPOSE: Advances in treatment have increased survival rates and quality of life of pediatric CNS tumor patients leading to a growing number of long-term survivors. However, there is sufficient clinical and scientific evidence for the need of a highly specialized lifelong follow-up care due to multidimensional late effects. Furthermore, adolescence and young adulthood are challenging age periods when patients frequently get lost to follow-up potentially having severe impact on health and well-being. Since 2020, we have established a structured transfer of long-term survivors older than 18 years to a newly founded highly specialized adult care follow-up setting for childhood cancer survivors (IONA). The aim of this study was to evaluate the current transition process. RESEARCH DESIGN: The standard of care transition process at the neuro-oncology unit of the MUV includes a joint appointment with the patient, a pediatric neuro-oncologist, psychologist, and the social worker and the team of the adult care facility (psychologist, social worker). Different elements are used to end care safely in the pediatric structure and building trust in the upcoming-out-patient-department at the same time. The transition process was evaluated statistically and analyzed qualitatively regarding to the factors that define a safe transition. RESULTS: After two years (01/2020-12/2021) 114 patients had a joint transition appointment, two patients contacted IONA directly. Shortly after the joint appointment all patients had a scheduled follow-up meeting at IONA. 1-3 months showed up, seven patients (1.7%) did not attend the appointment and were lost to follow-up. CONCLUSION: A structured interdisciplinary transition concept is a successful option to establish controlled and patient-safe transition from pediatric to adult care setting.

SWK-07. FAMILY MENTAL HEALTH SCREENING EARLY AFTER A DIAGNOSIS OF PEDIATRIC BRAIN TUMOR

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INTRODUCTION: A new diagnosis of a brain tumor in a child has significant emotional consequences for every member of the family. Nevertheless, early phases of oncologic care rarely provide formal mental health screening. METHODS: Social worker and the team of the adult care facility (psychologist) were visited in their office. They were asked about patients who came to them within the next 2 weeks after the child’s diagnosis, and completed the screening independently within the next 2 weeks via an online interface. Parent proxy reports for the children were used when necessary. Scores were shared with the family and neuro-oncology team. When indicated supportive counseling was offered. RESULTS: Eighteen patients have met criteria for mental health screening. Of these, 8 patient and parent dyads have completed the screening (mean age patient 8.6 years; 73% white; 30% female). Of the families that completed the evaluation, most parents (62.5%) reported that their child’s diagnosis negatively impacted their health-related quality of life (HRQL), while 87.5% of children themselves reported a lower HRQL. Most children (66.7%) self-reported having symptoms outside of normal range for anger, anxiety and depression and 100% had scores outside of normal range for pain interference with their daily lives. Only half of eligible families accepted referrals for new mental health support. CONCLUSION: Both children with a new diagnosis of brain tumor and their parents are at risk for impaired mental health and quality of life early after diagnosis. A systematic approach to these concerns at the time of diagnosis may be helpful.

SWK-08. IMPLEMENTING AWARENESS PRACTICE IN NEURO-Oncology

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Awareness practices are mind-body medicine techniques that help quiet the chatter of worry, fear, or the "to-do list" in the mind and allows the individual to experience calm and focus. Neuro-Oncology families undergo a variety of stressors that increase the "mind chatter" once their child is diagnosed with a brain tumor. These families not only have to manage the day-to-day tasks of family life, but they are thrust into a world of uncertainty which often can breed anxiety. To help mitigate the stress and anxiety that Neuro-Oncology families undergo, sessions focusing on awareness practices were offered to parent caregivers once a week for 15-20 minutes via the Zoom platform. The goal of these sessions was to foster respite from mental and emotional challenges brought on by the cancer diagnosis and the COVID 19 pandemic. Separate sessions were also offered to Oncology nursery case managers to help decrease compassion fatigue as these nurses also walk through the cancer journey providing advocacy for the child and patient/family support. Breath awareness, imagery, and meditation practices were used during the sessions to activate the body’s relaxation response to allow for rest and restoration.

SWK-09. BASELINE SURVEY OF HEMATOLOGY/ONCOLOGY/CELLULAR THERAPY STAFF/FACULTY PERCEPTIONS OF PALLIATIVE CARE

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Recent literature has shown that pediatric oncology patients and families prefer early integration of palliative care, yet the perception persists by staff and providers that palliative care has a negative connotation. We examined the baseline views of staff at our tertiary care center, prior to expansion of a formal palliative care service, as this will describe baseline survey results in a diverse group of hematology/oncology/ cellular therapy staff/faculty. This quality improvement project was conceived by the unit-based palliative care committee to compare baseline and follow-up survey results. We report the baseline results of a convenience sample of providers who completed a validated survey for staff perception of palliative care found in the literature was utilized. After institutional qualitative review board approval, the survey was emailed to members of the inpatient and outpatient units. Demographic data collected included gender, level of education, role, patient care experience, length of career globally and locally. Perception of palliative care was evaluated by asking questions regarding 1) overlap with disease focused care, 2) risks/benefits of palliative care, and 3) timing of palliative care consults. Results were to travel. The team developed relationships with the clinical team at the time. A follow-up survey is planned after integration of the developing formal palliative care service. Longitudinal comparison with statistical analysis will be completed at that time. Although most participants disagreed that palliative care is inconsistent with cure-focused care and that early palliative care does not induce parental anxiety, yet is perceived by the lay public as end-of-life care. Strong agreement was demonstrated with items regarding integration of palliative care early in the disease trajectory to decrease suffering. Participants also predominantly agreed that education for oncology providers and staff/faculty would ameliorate misconceptions about palliative care. Future evaluation after increased palliative care penetration will provide comparison data.

SWK-10. SURVIVORSHIP: EDUCATION, CLINICAL GUIDELINES, AND TRANSITION TO ADULT CARE

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As the cure rates of patients with pediatric brain tumors increases, the long term care needs of the survivors increase as well. Survivorship includes several facets of multidisciplinary care including education, clinical care guidelines, and transition to adult medical care. The neuro-oncology program at a large tertiary care hospital has developed a team to address survivorship needs. The Children’s Oncology Group (COG) Long Term Follow-Up Guidelines for Survivors of Childhood, Adolescent, and Young Adult Cancers was utilized as a backbone that was then customized for neuro-oncology patient education including disease type and treatment. The education was compiled into patient handouts as well as electronic medical record (EMR) statements that can be easily added to a clinic note or letter to referring providers. In addition, a diagnosis and treatment summary was placed both in the EMR as well as given to patients at various time points to expand their long term knowledge. Next, follow-up guidelines and roadmaps were developed and customized to tumor type and treatment received (surgery, radiation, chemotherapy). The roadmaps ensure patients are receiving high-quality comprehensive follow-up and screening from a large multidisciplinary team. Finally, patients will transition to adult care. With a large seven state catchment area, the adult care providers vary on local provider availability, knowledge, and medical complexity of the survivor. Each patient is evaluated based on their needs, availability of care locally, and ability to travel. The development of relationships with the clinical team at the academic center adjacent to the pediatric hospital to support a smooth transition to adult care. The adult neuro-oncology care team can also serve as a consulting service for local adult providers. The survivorship team will continue to address the complex needs of brain tumor survivors and provide education for a smooth transition to adult care.