Abstracts

Oral Presentaton Abstracts

OD 1
A CROSS-SECTIONAL STUDY TO MEASURE RATE OF OPIOID USE DISORDER IN PATIENTS ON LONG-TERM OPIOID ANALGESIC THERAPY FOR MANAGEMENT OF CHRONIC CANCER PAIN

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Background: India has a high incidence rate of cancer. During the year 2001, nearly 0.80 million new cancer cases were estimated in the country and this number is expected to increase to 1.4 million by 2020. A large proportion of these patients presents to the specialized health care settings in advanced stages and suffers from chronic cancer pain. Opioids are invaluable drugs for management of cancer pain. Despite the proven efficacy of opioid medications for treating cancer pain, the long-term use of these medications is riddled with issues such as aberrant drug taking behaviors, physical dependence, addiction, abnormal pain sensitivity, and cognitive dysfunction. In the backdrop of increasing burden of cancer patients in India and the initiatives by the Indian government to increase availability of opioid drugs for those in need of it, it is important to assess the rate of opioid use disorders among those who are on long-term opioid treatment for cancer pain.

Objective: To find rate of opioid use disorder in patients undergoing management of chronic cancer pain with opioid analgesics and to assess its association with demographic, clinical and treatment characteristics of the population.

Methodology: A cross-sectional study was conducted at the Department of Palliative Medicine, IRCH, AIIMS, New Delhi. Those patients who were being prescribed opioid analgesics for management of chronic cancer pain for equal to or more than 12 months, uninterruptedly and those receiving equivalent morphine dosage of equal to or more than 60 mg, in the most recent prescription, aged more than 18 years and willing to participate in the study and providing written informed consent were included in this study. Then study subjects were assessed using the study questionnaires. This included the semi-structured socio-demographic proforma, semi-structured proforma for details regarding current diagnosis and analgesic use, MINI version 7, the WHO-ASSIST Hindi questionnaire and the Addiction Behavior Checklist in that order. A psychiatrist further assessed those who score between 4 and 26 on WHO-ASSIST and the final diagnosis was recorded as per the ICD-10 for substance use and dependence. If a participant scores 3 or more on the checklist he was further assessed by a psychiatrist to make a clinical diagnosis of opioid use disorder as per the DSM-5 criteria for the opioid analgesic being used. Following the assessment, the patient was asked to provide a urine sample in the urine drug test cup to test for recent use of cannabis. The findings from each of these assessments was recorded for further analyses.

Results: Of the 28 participants, 67% were female and 33% were male with 33% in stage IV disease and 80% having a status of advanced malignancy stable disease. The longest duration of morphine consumption was found to be 216 months or 18 years with average morphine consumption/day of 264.66 mg (highest 2160mg/day). 67% of the patient did not required SOS dose and 33% patients had proxy visitors (relatives). None of the patient had any past or present psychotic behavior or any major depressive disorder. All of the patient had score more than 4 (ASSIST screening tool) and that required further monitoring and evaluation with addiction behavior checklist and only 13% of patient was recorded to have score of >=3 and further psychiatric consultation was done and none of the patient was diagnosed with opioid use disorder or opioid addiction or dependence (according to DSM-5 criteria).

Conclusion: Although the prevalence of cancer shows increasing trend in India and opioid is must for chronic cancer pain control. This study reports no case of opioid use disorder and the reason being proper monitoring, counseling, follow-up and limiting the use of morphine in chronic cancer patients with advanced malignancy.

OD 2
ANALYZING ADHERENCE AND MISDOSING PATTERN OF ANALGESICS IN A TERTIARY PALLIATIVE CENTER OUT-PATIENT DEPARTMENT

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Background: Cancer pain is one of the most difficult pains to be treated. Non-adherence to medication intake as prescribed is considered to be one of the important causes for this. Also, there is limited data from our country addressing this problem of adherence to pain prescription.

Aim: To analyse the adherence and misdosing pattern of drugs amongst patients presenting to a tertiary palliative centre out-patient department (OPD).

Materials and Methods: The single - centre, cross sectional, observational study included 155 oncology patients presenting consecutively, for follow up, at our Pain and Palliation OPD, according to selection criteria. Demographic data as well as data obtained using specially structured questionnaire aimed at analysis of adherence to pain prescription as well as associated barriers was collected. For the purpose of this study, any decrease in dosage or frequency of drug intake to that prescribed was considered as non-adherence and any patient taking excessive dosages of the drug (other than prescribed SOS doses), taking a drug for pain and palliation not prescribed by our clinic or taking drugs with adverse interactions amongst each other was separately classified as misdosing.

Results: The rate of non-adherence was 68.39% (106/155) and that of misdosing was 32.9% (51/155). We did not find any statistically significant association between gender, age, patient education, or stage
Ketamine produced significantly better reduction in pain than morphine. Of the 74 patients prescribed morphine, 62.16% (46/74) were non-adherent and 40.53% (30/74) were misdosing. Of note was the finding that 93.48% patients non-adherent to prescribed morphine had mild pain on treatment. However, 60.56% (43/71) of patients prescribed tramadol were compliant and of the non-adherent patients, 70% had mild pain. Only 9.46% (7/74), and 8.45% (6/71) of patients taking morphine and tramadol respectively, took prescribed SOS doses. 35.43% (45/127) patients taking paracetamol were non-adherent and 12.6% (16/127) were misdosing. The most common reason for non-adherence was found to be satisfactory pain control (33%), and that for misdosing was overlapping of prescription from different departments (9.03%) and misunderstanding prescribed doses (9.03%).

Conclusion: Pain is a symptom, very well and only appreciated.

Keywords: Adherence, analgesic, compliance, pain.

**OD 4**

**GOING THE EXTRA MILE-BARRIER TO CANCER PAIN TREATMENT: INDIAN SCENARIO IN 2017**

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Introduction: Adequate cancer pain management is an imperative area for holistic patient care which is hindered by access to opioids. In developing countries like India, patients need to travel long distances for access to opioids.

Objective: To document patterns/concerns of travel for cancer patients visiting specialist outpatient pain clinic for pain relief.

Methodology: Cross-sectional descriptive study conducted at pain clinic outpatient department at Dr B.R.A IRCH, AIIMS, New Delhi, India. Adult patients were eligible to participate in the study if they had histologically documented diagnosis of cancer and were registered at pain clinic OPD for >1 month. Spearman correlation was used to determine association between variables.

Results: The median age of participants was 47 years (range-18-79) and 58.11% (n = 68) were males. The median pain score was 7.5 (range-0-10). Majority of the patients (87.17%) travelled by public transport. The distance travelled in one way (to get to OPD) was ≤50 Km for 53 (45.30%), 51-500 Km and >500 Km for 35 (29.91%) and 29 (24.79%) respectively. Similarly, the travel time ranged from <1 hour to >24 hours. Nearly 68% patients reported easy access/availability to community transport but 71% were not satisfied with their travel times/distances. More than 72% believed that transport for cancer pain treatment had been a financial burden to family. Higher financial burden was significantly associated with dissatisfaction due to travel concerns (p < .001).

Conclusion: This study highlights the need to foster easy access to opioid analgesics at local places to improve outcomes with cancer pain management in India.

**OD 5**

**SPIRITUALITY: REFORMING MEDICINE, MEDICAL EDUCATION AND RESEARCH IN INDIA**

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Background: Intuition, ethics, compassion and Professionalism are the core competency of Physicians. ‘Being a good Physician’ cannot be taught through any specific education program.

Nowadays, the major purpose of conducting a research project is publication. Criteria for faculty promotion should not be based solely on publications. Assessment of a good teacher to promote him
solely on these criteria is an injustice. ‘Pub Med Fever’ is the state of Medical student’s participation in research to publish their work will become a pandemic and so cured by discouraging the culture of equating research publications in postgraduate Medical education. Forcing Medical faculty to do research, results in directionless research in Medical colleges. India has a long standing and well evolved Medical education system with the presence of AIIMS-like institutions. The brain perceives the world, plans for the future, sleeps, wakes, fears, desires and sometimes dreams of happiness. Sarva-sastra-prayojanam-atma-darshanam: “The end of all the science is to know our own self.” Medicine is to include the theory and practice of PRANAYAMA along with the Physiology of Breathing in the 1st year MBBS course.

OD 6
SPIRITUALITY CARE AND YOG (YOG IS SUPER MEDICINE)
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Introduction: Yoga is a group of physical, mental and spiritual practices or disciplines, which originated in ancient India. Yoga has a meditative and spiritual core and helps in controlling the body and mind. I am Prashant Shukla belonging to Allahabad and I completed my graduation in Electrical in 2016. I started practicing ‘dhyan’ when I fell victim to jaundice. My health was deteriorating and at that time ‘dhyan and pranayam’ helped me to overcome that situation. After that I started practicing ‘Aasans’ by observing nature and reading books and adopted ‘Yoga’ as a life style. I believe in energy and to me age is just a number and all of us are form of energy irrespective of gender.

Objective:
1. To make the world healthy and peaceful
2. To spread Indian vedic knowledge and culture all over the world
3. Spread the technical way of spirituality for easy understanding.

Methods:
1. I observe the mental and physical condition of the student’s energy
2. Then I try to boost the energy by Yogic method and Psychological input command
3. Imbalancing the brain to insert only positive thoughts
4. Random changes for creating fun and interest.

Results:
1. First of all, my life got changed totally. I am full of energy, strength and positivity
2. Mind and soul become peaceful and all the negative energy is thrown out of the body
3. People get rid of their long term addiction like smoking
4. Those who were entirely relying upon medicines, started living a healthy life without medicines and full of happiness.

Conclusion:
1. Concentrate on your strength so that no space shall remain for weakness
2. Yog is our heritage, which gives us the most valuable treasure that is ‘health.’
in the treatment of SPMI and if palliative care approaches can be considered as an option.

**Methods:** 1311 members of the Swiss Association of Psychiatry and Psychotherapy (SAPP) were invited to participate in a questionnaire-based study. The survey items asked about the importance of different goals of care such as impeding suicide, reduction of suffering, palliative care approaches, and curing the illness in the treatment of patients suffering from SPMI. In addition, three case vignettes with patients suffering from SPMI were presented and relating survey questions were asked.

**Results:** Findings of the survey are presented.

**Conclusion:** The survey aimed at fostering the understanding of how psychiatrists in Switzerland conceptualize SPMI, and discusses the goals of care for this vulnerable group of patients including the possibility of implementing palliative care approaches. Furthermore, it will be discussed whether the findings could be generalized to other mental healthcare systems, and whether palliative psychiatry is equally meaningful in developing countries where resources for and access to standard interventions may still be limited.

**OD 9**

**Spiritual Wellbeing versus Psychological Wellbeing: Which is the Better Navigator for Quality of Life?**

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**Background:** Quality of the life lived plays an important role in shaping one’s attitude towards impending death. Achieving optimal Quality of life (QoL) for their patient and their caregivers, is the ultimate goal of all palliative care services. Including QoL assessment and goals would bring a more systematic approach to clinical and psychosocial interventions.

This study explored the two indicators for measuring a patient’s quality of life – spiritual wellbeing and psychological wellbeing. A systematic review of online journal articles was done with the key words “spiritual wellbeing”, “spirituality and quality of life”, “psychological wellbeing and quality of life”, “quality of life indicators” and “quality of life”. The results led to some interesting insights regarding spiritual wellbeing and psychological wellbeing (PWB) as indicators of one’s quality of life. PWB’s quantifiable markers bring a more tangible approach, while spirituality is more subjective, aiding to a customized intervention plan – stimulating a refreshing debate.

**OD 10**

“My Dreams are all gone” – End of Life Issues in Adolescents and Young Adults: A Qualitative Study

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**Introduction:** Adolescents and young adults (AYA) in palliative care are a vulnerable group and terminal illness poses a challenge to their physiological and psychological development. AYA have very specific concerns, and their needs are different from that of children and the elderly. For palliative care systems to develop specific interventions, there is a need for increased understanding of the unique factors that influence their quality of life (Nass et al., 2015).

**Objectives:** To understand the lived experience of AYAs with terminal cancer and study psychological and social factors affecting their quality of life.

**Methodology:** The qualitative study used a phenomenological approach to analyze narratives from interviews with 10 patients, 10 family care givers and 8 health providers. The interviews were audio recorded and transcribed. Coding was done by two independent researchers and themes identified.

**Results:** The various themes that emerged included some that were similar to that affecting QoL in most other phases of life. However, AYA specific themes that were identified included Shattered dreams and aspirations, not being able to be part of peer group, body image issues, guilt of not taking up responsibility, being a burden, existential issues. Many AYAs coped by altruism, stoicism, connecting with others and creativity. There was ambivalence in relation to spirituality and several felt that health care professionals did not meet their expectations.

**Conclusion:** The concerns of AYA specifically need to be understood, to plan interventions to improve their quality of life, and to sensitize health professionals to be more responsive to their needs.

**OD 11**

Extrinsic Environmental Risk Factors for Fall in Elderly People in Rural Thirubhuvanai, Puducherry

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**Background:** Most households in rural India have potential environmental hazards for fall among elderly. There is limited information available on magnitude of these factors in our context.

**Objective:** To assess the house and surrounding environment for potential environmental risks of fall in elderly people.

**Methods:** The present study was done in villages of Primary Health Centre (PHC) Thirubhuvanai in Pondicherry. It was a cross sectional study. A representative sample of 342 households of elderly (>65 years) were observed for risk factors using pre-designed checklist, which was carried out by trained post-graduates in community medicine. The risk factors observed were slippery floors, inadequate lighting, unstable furniture and obstructed walkways. The study was approved by Institutional Ethics Committee. Frequencies of variables were obtained by using Epi Info software (Version 7.2.1.0).

**Results:** Out of 342 houses, majority were pakka 176 (51.5%) and most of the house floor was made of cement 198 (57.9%). Unstable
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furniture was present in 203 (59.4%) houses. Out of 342 houses, latrine was present in 179 (52.3%) houses. Among houses, where toilet was in use 141 (78.8%), only 9 (6.4%) toilet had support. Bathroom was present in 185 (54.1%) houses and only 6 bathrooms (3.7%) had support. Majority of the houses had adequate lighting in living room and toilets; however, it was relatively low in kitchen.

**Conclusion:** Majority of household had potential environmental risk factors for fall such as unstable furniture and lack of support in toilet. Interventions at household level are required to minimize these risk factors.

**OD 12**

**AYUSH INTERVENTIONS IN PALLIATIVE CARE**

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**Introduction:** With the Social evolution all human societies had medical beliefs for providing explanations and responses to, birth, disease and death throughout the world. The rise of scientific medicine in the past two centuries has changed the scenario by unfurling the mysteries.

**Objectives:** India has no dearth of medical treasures which successfully worked till they were almost replaced by Modern Medicine, it is right time to explore the use of alternative medical systems in Palliative Care which are still widely used across the country so as to make it cost effective. Since Government of India is promoting alternative medicine under AYUSH Ministry, there is need for integrating Palliative Care to improve efficacy and make them cost effective.

**Methods:** To achieve the above a Conference is planned involving all the stakeholders such as Allopathy, Ayurveda, Unani, Yoga and Homeopathy so as to integrate them in Palliative Care towards larger interests of the Patients.

**Results:** It was interesting to note that people from various streams had shown keen interest in this approach and agreed to cooperate by giving their consent as Member of the advisory committee. Further they agreed to give lectures during the conference on the mentioned theme.

**Conclusions:** Since the conference is proposed on December 8th 2017 the final outcomes are awaited however it has been seen that the respective stakeholders are enthusiastic as well as find the approach very effective in treating the pain and other distressing symptoms so as to improve the quality of life.

**OD 13**

**VALIDATION OF TRANSLATED VERSIONS OF “FAMCARE-2” FOR FAMILIES OF ADVANCED PEDIATRIC ONCOLOGY PATIENTS IN A TERTIARY CANCER CENTRE**

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**Introduction:** Palliative care (PC) involves comprehensive care of the patient and family. Family caregivers’ satisfaction is the moral duty of the PC provider. FAMCARE-2 is one of the simplest, multidimensional and widely used tool. Hindi and Marathi (H/M) translations will greatly benefit the large non-English speaking population in India.

**Objectives:** Primary: To demonstrate the validity and reliability of the H/M versions of FAMCARE-2.

Secondary: To establish its:
1. content validity
2. reliability,

**Methods:** Study design: Observational. 170 participants (85 each for H/M) were enrolled in the study.

Inclusion criteria: The parents of a child with locally advanced or metastatic solid organ cancer, or a relapsed or refractory hematolymphoid cancer, receiving PC and able to complete the questionnaire in H/M.

Exclusion criteria: Not consenting/not understanding H/M.

Statistics: Descriptive statistics were used for participant characteristics. Content validity was evaluated by factor analysis. Inter-subscale correlation evaluated by calculating Pearson’s correlation coefficient and Internal consistency by calculating Cronbach’s α.

**Results:** [summarized in Table 1]

For both H/M versions, 1. Validity: Each item in the scale was found to be appropriate in determining carer satisfaction and that no items should be removed from the scale.

2. Reliability: A Cronbach’s α coefficient of more than 0.7 indicates a high level of internal consistency implying that all of the items in the scale measured the same construct

**Table 1: Results**

| Descriptive statistics | FAMCARE-2 Hindi | FAMCARE-2 Marathi |
|------------------------|----------------|------------------|
| Validity               |                |                  |
| Content validity       |                |                  |
| (factor analysis)      |                |                  |
| **Shows that each subscale represents and correlates with each dimension** | | |
| Inter-subscale correlation | Pearson’s correlation coefficient (r) | 0.765 | 0.581 |
| The KMO                | 0.765          | 0.581            |
| Item-to-total correlation coefficient | 0.33–0.74 | 0.28–0.73 |
| Reliability            |                |                  |
| Internal consistency:  |                |                  |
| Cronbach’s α           | 0.910          | 0.722            |
| Correlation            | >0.05          | >0.05            |
| P values of correlation between demographic variables and FAMCARE-2 scores | | |
| KMO: Kaiser-Meyer-Olkin | | |

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OD 14
EXPERIENCES OF PARENTS CARING FOR A CHILD WITH RETINOBLASTOMA: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

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Introduction: Parents of the children with retinoblastoma exhibit high levels of emotional distress. The study aims to explore the lived experiences of parents caring for a child with retinoblastoma in India.

Methodology: Parents caring for a child with retinoblastoma for at least 12 months were identified and invited to participate. Eligible consenting participants were interviewed and the transcripts of the interviews were analysed using an Interpretative Phenomenological Analysis (IPA) method. Study findings were interpreted using the theoretical lenses of Bronfenbrenner’s ecological systems theory.

Results: 8 (eight) parents of the enucleated children and 7 (Seven) parents of the non-enucleated children participated in the study. Four major themes were identified during the data analysis.

Theme 1 demonstrated that parents had a high expectation and a strong desire to provide the best care for their children. The wished to be ideal parents and yearned to be the eyes of their children.

Theme 2 demonstrated that parents experienced extreme negative emotions during caregiving. Parents experienced guilt, fear, loneliness and mistrust.

Theme 3 demonstrated that caregiving process was distressful for the parents. Distress was due to loss, uncertainty, caregiving fatigue, spiritual and existential factors.

Theme 4 identified parental coping strategies. Parents benefitted from continuing faith in God, peers, compassionate healthcare providers and self-strategies. Parent’s caregiving microsystem and macrosystem had a balance of positive and negative features that balanced the experience of caregiving. However, the failure of parent’s caregiving mesosystem, exosystem and chronosystem led to negative experience of caregiving.

Conclusion: The experience of caregiving was similar among parents of enucleated and non-enucleated children. Parents of both the groups had an overall negative experience of caregiving.

OD 16
PROVIDING SPIRITUAL SUPPORT TO CHILDREN WITH PROFOUND DISABILITIES

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Introduction: Spiritual care is an essential part of palliative care, yet often poorly done. Children with profound disabilities related to advanced life-limiting illness seldom receive spiritual care due to difficulties with assessment and providing their response to care.

Objectives: To develop a protocol to provide spiritual care to children with profound disabilities related to advanced illness or traumatic accidents for a children’s hospice palliative care programme in South Africa.

Methods: Identification of core elements of the globally acknowledged Consensus Definition of Spirituality in Health Care – meaning and purpose and connectedness to self, others, nature, the sacred. Developing individual spiritual care plans so each child receives spiritual care related to all these elements of the definition daily through specific activities such as touch, massage, music, mirrors; interaction with nature; candles, rituals. Assessment carried out through evaluation of reactions to activities, comfort, reaction to others, response to nature, sacred rituals. When the child is unable to show response a comfort scale is used.

Meaning and purpose is assessed through discussion with the child’s family, the staff and volunteers so is external to the child. Where the...
child can speak and understand they are assessed for what gives their life meaning and the plan includes strengthening this.

**Results:** Children in the hospice programme receive holistic palliative care spiritual care which includes spiritual care to meet individual needs. Assessment of levels of comfort, interaction with others and relaxation and/or happy facial expressions are presently used to assess response. Assessment is difficult with profoundly disabled children and is acknowledged as being subjective when the child cannot respond verbally.

**Conclusion:** Just because profoundly disabled children cannot respond to spiritual care is no reason not to provide this care. Further research is needed but ethics approval is difficult to obtain with this vulnerable population.

**OD 17**

**REHABILITATION OF PARAPLEGIC PATIENT (HALF WAY HOME)**

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**Introduction:** Pallium India with the financial support of Social Justice Department started this project of Halfway Home in the Year 2014-15. During the third year, 2016-17 period, special stress was given to vocational rehabilitation of the patients in addition to routine rehabilitation activities.

**Background:** The number of patients due to spinal cord injury is substantial and the physical, psychosocial and economic morbidity that follows remains a matter of utmost significance as most of the spinal cord injury patients are from the productive age group. This made us to realize the significance of the issue of vocational training and rehabilitation and to give it the priority that it deserves.

**Objectives:**
- Addressing the physical and psychosocial problems
- Training to improve daily living skills
- We teach him basic cooking and to conduct toilet chores without help
- Counseling and to adjust as better as possible
- Training in some vocational skills to gain the self-esteem.

**Methodology:** We address physical, psychosocial and spiritual problems and then a plan of management was prepared. A Multi-Disciplinary Team was formed and that including Urologist, Surgeon, Psychiatrist, Psychiatrist and Nutritionist Palliative Care Team. Out of the 18 patients in 2016-17, 5 were quadriplegics and 13 were paraplegics. 14 of these had pressure sores and two among them had to undergo plastic surgery.

**Outcomes:** 14 of these patients were changed from indwelling catheter to intermittent self-catheterization and to stave off social embarrassment of the patient Urinary infection was present on admission in 13 patients. Psychological screening was done in most cases. But in 4 cases severe depression with suicidal ideations were noticed and were subjected to psychiatric consultation. All patients were started on anti-depressants and initial counseling was done. In those with severe depression counseling and follow up was done continuously.

As part of vocational rehabilitation skill development training was given to all. Three of these patients were trained for two months in catering by the Central Government Institute of Catering Technology at Kovalam.

**Conclusion:** Halfway Home is a concept that equips the patient and family to adjust and lead a life that is economically independent and socially satisfying. We could realize that many more aspects have to be dealt with in achieving this goal.

**OD 18**

**TRAINING NEEDS: EXPERIENCE, RESEARCH AND VISION OR: WHAT IS THE FUTURE LARGE SCALE PALLIATIVE CARE TRAINING NEED IN INDIA? INSIDE OBSERVATIONS/EXPERIENCES/VISIONS AND RESEARCH**

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**Background:** Since Feb. 2013 with the approval of Central Government Secretary Health and Family Welfare (signed by S.K. Gupta; http://palliaction.com/images/pdf/Secretary%20Health%202013.pdf) and the support of German Central Government Health Ministry, the speaker supports local Universities at Mangalore (Yenepoya/Manipal) and others to enrich their knowledge of Palliative Care Teaching within their Medical and Nursing colleges.

The University of Aachen (RWTH) has send a team of researchers (Prof. Dr. F. Elsaer, head of palliative care training DGP and EAPC and his staff) to find out in a comparative study (St. Johns, Bangalore; Manipal/Yenepoya, Mangalore; Pallium India, Thrivanandapuram) about good practice of palliative care teaching. The Mangalorean results will be presented at IAPCON 2018.

The way of teaching is not e-learning focused (as this does not improve communication skills) neither 6-weeks-based field training (as it is consuming resources of trainers and addressed only the possibilities of junior staff), but more activating group-related teaching in 4 prolonged weekends (4 times 30 teaching hours) according to the EAPC white book Median Level of Palliative Care teaching.

So far three batches were trained as palliative care median level specialists at Manipal University KMC Attavar (including a train-the – trainer workshop) and two more at Yenepoya Nursing College. A sixth training group started in Dec. 2016 and was continued in Feb. 2017 and will be completed by end of 2017. Total number of qualified experts/trainers (most of them are assist. professors in their fields) is 95.

This work was not taken into any consideration by the National Faculty and the other stakeholders of Indian Palliative Care training so far, but very well supported and accepted as possible way of teaching by Raj and by Naveen.

Mangalore was installed as Palliative Care model city by the Karnataka Heath Ministry Palliative Care State policy. The speaker was present, when the preparatory meeting for this State policy was discussed in Feb. 2016. The training, with its specialty of Geriatric Palliative Care Training at Mangalore was part of mentioned in that meeting.
OD 19

DEVELOPING PALLIATIVE CARE IN UTTARAHAND: THE OUTCOMES OF ADVOCACY IN THE STATE

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Introduction: A small group of activists in Uttarakhand work tirelessly to raise awareness of palliative care (PC), assist government in policy changes and to improve the provision of services. Primarily teams from Ganga Prem Hospice, Himalayan Institute Hospital Trust and Seema Dental College, Rishikesh.

Objective: Review activities of PC activists and their impact.

Methods: Questionnaire to known PC activists and NGOs in Uttarakhand to determine:
- Sensitisation and educational activities conducted (January 2015 to November 2017).
- Additional activities taken to progress palliative care.
- Future plans for palliative care (short/long term goals).

Results: Achievements include:
- Over 50 SEA activities targeting 2385 participants
- International Pain and Palliative Care Conference 2015
- Active Hospice and Home care program (GPH)
- 6 PC beds: Sri Mahant Indresh Hospital, Dehradun with OPD
- Trained staff in several hospitals, 1 dental college
- 3 active NGOs; good collaboration
- Formation of Uttarakhand Palliative Care Network (UPCN)
- Part of North India PC Network
- PC included in Uttarakhand PIP program (2018); funding granted.

Future plans include:
- State PC policy.
- Opening of HIHT IPU Dehradun.
- Further collaboration between NGO and hospitals.
- Expansion of hospice IPU.
- Training for state health care professionals.

Conclusion: Strong role of activists in the development of PC in Uttarakhand, developing its provision rapidly. Advocacy plays a significant role in raising awareness of pc in resource poor countries as well as provision.

OD 20

IMPLEMENTATION OF SIMULATION-BASED END-OF-LIFE CARE TRAINING FOR NURSING STAFF IN LONG-TERM CARE SETTING

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Introduction: Traditional lectures combined with simulation technology can be used for end-of-life care training.

Objective: To assess the impact of simulation-based end-of-life care training for nursing staff.

Method:
1. Tools designed
   a. End-of-Life Care Pathway: clinical protocol for end-of-life care
   b. End-of-Life Care Didactic: education on care pathway, symptom management, nursing interventions
   c. Simulation Scenario: clinical scenario using computer-controlled manikin
   d. Observer Evaluation Tool: to assess participants during simulation
   e. Participant Evaluation Tool: to assess the effectiveness of training.
2. Training: Provided by physician and nurse; consisted of didactic and simulation scenario. Participants identified symptoms, administered medications and provided care using a manikin. Participants were assessed by Observer Evaluation Tool. Participants completed a pre- and post-training Participant Evaluation Tool rating their confidence in using the End-of-Life Care Pathway.

Outcomes:
1. 40 participants trained
2. Participants rated their confidence in using the End-of-Life Care Pathway on a Likert scale of 0-5, 0 being no understanding; 5 being fully confident. The average pre-training score was 3.6, which increased to 4.5 after the training
3. Using the Observer Evaluation Tool, it was noted that participants performed well (score of 4/4) in the areas of death pronouncement and postmortem care. The areas of care coordination (score of 1.4/4) and general patient care (score of 2/4) had opportunities for improvement.

Conclusion: Simulation-based training has the potential to enhance confidence of nursing staff in providing end-of-life care. Simulation can assist in identifying components of nursing practice and end-of-life care that could be improved.

OD 21

DEVELOPMENT AND IMPLEMENTATION OF PALLIATIVE CARE IN KERALA: HEALTH POLICY ANALYSIS

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Introduction: Kerala was the first state in India and first government in the developing world to adopt a palliative care policy, in 2008. Every primary health centre in the state now has one nurse with training in palliative care providing home visits to non-ambulant patients.

Objectives: To describe how Kerala’s palliative care policy was made, the extent to which the policy succeeded and the gaps that need to be resolved.

Methods: The study employed a qualitative research design with data was collected using chronological media review, key informant interviews with policy makers, stakeholders and health care
professionals. It uses the "policy analysis triangle" as a framework to evaluate the policy.

**Results:** The policy resulted from public-private participation. It succeeded in strategizing and channelizing resources and in reaching out through the primary care network. But it has touched only the fringe of the problem as indicated by per capita opioid consumption, inadequate participation of doctors in palliative care, lack of access to palliative care in tertiary hospitals, poor implementation of proposed monitoring machinery, inequity in care to vulnerable populations, in poor Government-NGO collaboration and particularly in poor integration of palliative care with most of the health care delivery system.

**Conclusions:** Palliative care policy of Kerala has been a giant step forward in access to palliative care and sagacious decision to tackle million’s sufferings, but needs to implement a monitoring mechanism and to take remedial action to fill current gaps. Let us hope new initiatives will make our society more equitable.

**OD 22**

**Knowledge on Risk Reduction/Prevention of Breast Cancer Related Lymphedema among Nursing Professionals in a Selected Teaching Hospital, Bengaluru**

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**Introduction:** Lymphedema development post breast cancer surgery has been identified as a major burden worldwide, and nurses are at the forefront of prevention/risk reduction practices. The purpose of this study was to determine the nurses’ knowledge regarding risk factors, prevention, and management of BCRL. Prevention is of key importance to avoid lymphedema formation.

**Objectives:**
1. To assess the knowledge regarding risk reduction/prevention of BCRL among nursing professionals
2. To compare the pre and post test knowledge regarding risk reduction/prevention of BCRL among nursing professionals.

**Methods:** One group pre and post test design (pre – experimental) was carried out after approval by the Research Ethics Committee at the study institution. Data were collected through validated questionnaire pre and post session based on National Lymphedema Network - Risk reduction/prevention of BCRL. Participants were 80 nursing professionals, of whom 80% were female staff nurses with 60% falling in the 25-34 years age group and 80% having up to 4 years experience working with BCRL patients.

**Results:** The mean percentage of correct answers on the knowledge test was an average of 54%, which post education intervention increased to 61%. The mean score increased from 4.286 [SD: 0.97] to 4.452 [SD: 1.51].

**Conclusion:** The results of the study have implications in identification of deficient areas which can guide strategic planning with a view to the dissemination and adoption of prevention measures by the team.

**OD 23**

**Teaching Task Shifting for Palliative Care in Suburban/Rural India**

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**Introduction:** Given the diversity in India, implementation of Palliative Care services should be based on region, culture and available institutional support. A team from the United States partnered with Sharon Palliative Care Center in Salem, India to study task shifting, a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. This tactic might prove useful to meet the disparity of care in certain regions.

**Methods:** 16 underprivileged girls undergoing training as nursing aides participated in a three-day intense training program. The material was easy to understand, reproducible and engaging. They were given a quantitative survey after completion of the course to assess understanding and satisfaction. They were also encouraged to give qualitative feedback.

**Results:** The results of the study are as shown in Figure 1.

**Conclusion:** Our study shows improvement in the confidence rating scales post intervention. With additional training and acquisition of skills and support, it suggests these nursing aid students can be trained to task shift to administer home based palliative and hospice services. This initial study was done to assess needs with plans to use the knowledge gained to provide community, home based palliative care services administered with task shifting concepts.

**Figure 1: Confidence Rating Scale**

**OD 24**

**Elders on a Journey: Upside-Down Normativity at a Training in Dementia Care**

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**Background:** Every June in Indiana, a dozen people gather for a training retreat on dementia care, run by a non-profit organization called Memory Bridge. According to its website, it aims “to create a global community of people who, like us, are learning to listen to
people with dementia for what they have to teach us about our own humanity.” Education, community building and advocacy are some of the strategies it uses to meet this broader goal, and the summer sessions combine these.

The curriculum includes storytelling, lectures, drumming and meditation.

But the core activity is daily interaction with elders at a memory care unit, followed by time in circles where people share feedback on these experiences.

This paper is drawn from a larger ethnographic study of the trainings in 2015 and 2016, where I explored the effectiveness of the program from the trainees’ perspectives.

I did fifty-seven unstructured interviews with trainees and organizers. I also attended and observed the classes and activities.

I found that by taking the experience of cognitively frail elders as central, by seeing the world from their perspective, rather than seeing them through ours, Memory Bridge encourages caregivers to question mainstream social norms. Participants’ usual internal monitors were to some extent replaced with the point of view of people living at the margins of society – people, sadly, who are often considered “gone” in North America. The pedagogy of the program raises profound questions about norms that rank cognition, appearance and persona management over affection and human connection.

**OD 25**

**Social Science Approaches to Palliative Care: Implications for Policy and Practice**

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**Introduction:** Despite the interdisciplinary nature of palliative care’s aims which are rooted in a multimodal approach to treating suffering, little research has focused on the implications of medical social science for palliative care practice and policy.

**Objectives:** To outline notable concepts in medical social science for their relevance to palliative care practice and policy.

**Methods:** A literature review was undertaken assessing the major conceptual contributions to medical social sciences alongside a parallel literature review of the foundational concepts of palliative care.

**Results:** The qualitative social science concepts of “social suffering,” “structural violence,” “local moral worlds,” among others, have significant implications for palliative care as a field of practice and as an area of growing research and policy interest worldwide. Each concept is discussed with an attention to how it could shape clinical practice and policy of palliative care.

**Conclusions:** Palliative care’s disciplinary focus on the relief of suffering requires multifaceted ways of gauging what constitutes successful palliative care delivery at the level of the patient and the population. Social science concepts and methodologies, which are increasingly gaining visibility in global health care and policy, can critically shape how palliative care physicians, policymakers, and researchers understand and practice in this rapidly evolving field.
Evidence: Indian National Health Policy (NHP) 2017 and other international bodies endorse palliative care as an essential health care service. NHP 2017 also recommends development of distance and continuing education options for general practitioners to upgrade their skills to avoid unnecessary referrals. India ranks 67 (very poorly) in the quality of death index. Two-third of deaths need palliative care, 75% of cancer patients present with advanced disease and a large number of palliative care patients die in intensive care units.

Methods: A taskforce was formed and brainstormed on integration, networking and bringing specialists and generalist physicians under one umbrella. The WHO model of taking a public health approach to palliative care was used; policy support, education and training, service development and availability of appropriate medicines.

Recommendations: Taskforce recommends the following:
1. Centers of palliative care expertise should integrate and network with family medicine physicians/generalists for education and clinical support
2. Implement the recommendations of NHP 2017 to develop services and training programs for upskilling of doctors
3. Include palliative care as a mandatory component in the UG/PG curriculum of family physician training
4. Improve access to necessary medications in urban and rural areas
5. All palliative care staff must have relevant training
6. Generate public awareness about palliative care and empower the community to support the dying.

OD 28
CONCEPT OF HOSPITAL PALLIATIVE CARE TEAM

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Introduction: The Hospital Palliative Care Team (HPCT) is a multi-professional team providing an advisory service to patients and staff at MGMCR. It is designed to complement the hospital services by providing evidence-based, individualized, symptomatic, complex psychosocial care and terminal care for all patients with cancer and advanced non-malignant disease by liaising with other specialist palliative care services (hospital and community). HPCT would endeavor support to family members who require help.

Hospital Palliative Care Team (HPCT) is encouraged to provide a trust wide advisory service to patients at MGMCR. The Team adopts a multi-disciplinary approach. The provision of a specialist palliative care support and symptom control is available at all stages of a patient’s treatment. The proposal is that Mahatma Gandhi Medical College and Research Centre take leadership in establishing a holistic palliative care service setting at Pondicherry to the incurably ill, bedridden, elderly, and dying people.

Functions of the Committee:
1. Development and dissemination of palliative care at scientific, clinical and social levels
2. Communicate clearly and compassionately with the patient and family
3. Able to reach common ground with respect to a management plan
4. Able to discuss prognosis.

OD 29
HOW STRESSED ARE PALLIATIVE CARE PHYSICIANS?

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Introduction: Palliative Care Physicians handle death and dying routinely. As times they handle patients whose symptoms may be refractory. Handling of emotions of patients and their care givers is often causes of stress.

Objective: This study aims at finding the stress levels of palliative Care Physicians at CanSupport. CanSupport is providing free Home Based Palliative Care to patients in Delhi and NCR for more than 20 years.

Methods: Maslach Burnout inventory was used to find the stress levels of Palliative Care Physicians.

Results: Though caring for the dying is stressful, most of the doctors felt exhilarated after working closely with their patients. They had feeling of accomplishment as they were able to positively influence the lives of patients and their care givers. Helping patients to live well and leave well gives physician’s great satisfaction.

OD 30
A SURVEY OF MEDICAL PROFESSIONALS IN AN APEX TERTIARY CARE HOSPITAL TO ASSESS AWARENESS, INTEREST, PRACTICES AND KNOWLEDGE IN PALLIATIVE CARE: A DESCRIPTIVE CROSS-SECTIONAL STUDY

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Background: Medical discipline in India focuses on cure rather than comfort care. Palliative care is concerned with improving quality of life and relieving sufferings in patients with advanced incurable terminal diseases. Palliative care in India is still in infancy stage due to lack of knowledge, attitude and skills among health care providers. The reason being lack of training in under graduate as well as postgraduate teaching curriculum and lack of sensitization among policy makers.

Objectives: To assess the awareness, interest, practices and knowledge in palliative care among medical professionals working in a tertiary care hospital.

Subjects and Methods: All participants were mailed proforma to be filled in a fixed format including details of their qualification, demographic data, their field of work, their training in palliative care and multiple choice questions regarding awareness interest, practices and knowledge of palliative care.
Results: Out of 186 respondents, 56% had not received any basic training in palliative care. 81% wanted palliative care education to be included in undergraduate curriculum. Poor program was identified as the most common barrier in learning palliative care. 77% respondents had no idea about home based palliative care services. 50.8% patients dies in hospital in their terminal stage. 88% were interested in learning safe opioid practices. Although 89.8% were aware of the need of palliative care in metastatic cancer but less than 50% were aware of the fact that palliative care is also required in MDR-TB and mental illness.

Conclusion: This study reflects data of an apex cancer institute of the country. The result of awareness is not very encouraging despite a dedicated palliative care department. So, we can assume what will be the palliative care status in other parts of India where there is no palliative care at all.

Recommendation: We strongly recommends that palliative care teaching should be incorporated in undergraduate curriculum to sensitize the students from the beginning. Budding residents in their learning phase can play an important role by learning and providing palliative care as the first person to come into contact with the patients are residents. There is a strong need of spreading palliative care awareness all over the country.

OD 31

IMPACT OF PROJECT HAMRAHI IN IMPROVING ACCESS TO PALLIATIVE CARE SERVICES IN A RURAL HOSPITAL IN NORTH EAST INDIA

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Background/Aims: Project Hamrahi is a collaborative venture between Australia Palliative Link International (APLI) and Pallium India in which a doctor-nurse team from Australia/New Zealand builds a relationship with one nascent palliative care centre in India. This paper aims to explore the impact of all the visits made by Australian palliative care physician Dr. David Brumley and his team at Cachar Cancer Hospital and Research Centre (CCHRC), Silchar, Assam.

Methods: With an aim to improve the academic and cultural exchange, Project Hamrahi has endeavored to engage a group of western professionals in giving sustained support to palliative care units in India.

Results: Since 2012, four Hamrahi visits to CCHRC have taken place, which has committed atleast 1 week of visit each year. They spoke in various forums to raise awareness of the needs of palliative care. They worked with the palliative care team and did sessions on various topics on palliative care at the bedside and through several video conferences. They accompanied the team on their ward rounds, in OPD and satellite centres, conducted home visits, and provided administrative guidance. They supported the six weeks training of several palliative care nurses at Hyderabad and Trivandrum with generous donations to our hospital. Their recommendations helped in ensuring judicious use of morphine and improved its documentation in the ward, helped in adopting universal precautions for hospital staff and self care, improved discharge systems with better documentation, helped in bettering communication skills and confidence of the nurses and lessened patient re-presentations through education of the family, implementation of the subcutaneous route of drug delivery and strategies to prevent burnout.

Conclusions: The visit of APLI members has made a positive impact. Each visit was unique and it opened avenues for mutual academic learning, fostering relations, capacity building and collaborative research across cultural, resource and other barriers.
Abstracts

Introduction: Most countries face the challenge of meeting the growing needs of the ageing populations. Now is the time to broaden our concept of palliative end-of-life care with a proactive population-based person-centred approach.

The Gold Standards Framework (GSF) quality improvement programmes, extensively used in the UK take a population-based approach, focusing on 1% of the population in their last year of life, and 30% hospital patients, encouraging pro-active, person-centred systematic care for all.

Objectives: To describe the impact of a comprehensive inclusive population-based approach in end-of-life care to meet the needs of the whole population, in any settings with any condition. This quiet revolution is beginning and this presentation describes early successes using the Gold Standard Framework Programmes (GSF) programmes in all settings in the UK.

Methods: Comparative evaluations using EOLC metrics is intrinsic to GSF, support assessment of progress and impact and will be described in hospital and community settings used over the last 20 years.

Results: Key results of frontrunning teams are described including identifying over 30% hospital patients, offering 75% of them initial advance care planning discussions, leading to reduced hospitalisation and more dying well at home. Similarly in primary care and care homes.

Conclusions: It is possible to take a broad population-based view of EOLC that also can be most cost-effective, equitable use of resources. With India’s changing demography, and growing palliative care, can we extend these concepts to meet the changing needs of India’s population.

The Gold Standards Framework (GSF) quality improvement programmes, extensively used in the UK take a population-based approach [Figure 1], focusing on 1% of the population in their last year of life, and 30% hospital patients, encouraging pro-active, person-centred systematic care for all.

Introduction: Rwanda is among the first African countries with a palliative care (PC) policy and implementation plan. A partnership with the Ministry of Health (MoH) through the Rwanda Biomedical Centre (RBC) and the University of Edinburgh has supported an integrated approach including expanding the evidence base.

Objectives: To assessing the need for (PC) to inform policy, service delivery and training.

Method: A point prevalence PC needs assessment was conducted in nine public hospitals (referral, provincial and district). A records census identified those with life-limiting illness (LLI) who were then invited to participate by interview. The assessment tool included the APCA African POS, POS S, WHO performance status and demographic information.

Results: 608 case notes were reviewed, 152 eligible and 124 completed assessment. 25% of all patients admitted had LLI, of which 99.2% had evidence of unmet need determined by at least one score on the APCA POS ≥3. Diagnoses 29% cancer, 29% cardiovascular disease, 16.9% end-stage organ failure and 13.7% HIV. Symptoms with greatest impact; nausea and vomiting (34.7%) and pain (32.3%). 63.7% with WHO performance status 4 or 5. 8.1% seen by existing PC services.

Conclusions: Although the MoH and RBC are making bold steps towards developing PC in Rwanda, there remains a significant amount of unmet PC needs. Meeting this need requires recognition of the scope of PC needs beyond cancer, feedback to the hospitals and health care workers, thinking strategically how to further strengthen the health system and further capacity building and training.

OD 35
INTEGRATING PALLIATIVE CARE; IMPACT OF A 5 YEAR STRATEGY FROM THE MAKERERE AND MULAGO PALLIATIVE CARE UNIT

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Introduction: Makerere and Mulago Palliative Care Unit (MPCU) aims to operate a centre of excellence to improve access to quality, evidence-based palliative care (PC) for patients and families by delivering an integrated clinical service within the national referral hospitals site; carrying out research, training and capacity-building in collaboration with partners and developing leaders in PC.

Objectives: To evaluate and assess outputs and outcomes from the strategic plan 2011-2016.

Methods: A review of indicators using the database and outcomes integrated within the research agenda including capacity building, training numbers, and collation of impact assessments. A review of research capacity included online survey, qualitative interviews and qualifications attained by MPCU staff.

Results: 3,189 patients seen directly by MPCU with additional 6,669 seen by link nurses (731 referred). 4,630 individuals trained including

Figure 1: A population-based approach to end of life care

OD 34
ASSESSMENT OF PALLIATIVE CARE NEEDS IN HOSPITAL SETTINGS IN RWANDA

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Introduction: To describe the impact of a comprehensive inclusive population-based approach in end-of-life care to meet the needs of the whole population, in any settings with any condition. This quiet revolution is beginning and this presentation describes early successes using the Gold Standard Framework Programmes (GSF) programmes in all settings in the UK.

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Results: Key results of frontrunning teams are described including identifying over 30% hospital patients, offering 75% of them initial advance care planning discussions, leading to reduced hospitalisation and more dying well at home. Similarly in primary care and care homes.

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The Gold Standards Framework (GSF) quality improvement programmes, extensively used in the UK take a population-based approach [Figure 1], focusing on 1% of the population in their last year of life, and 30% hospital patients, encouraging pro-active, person-centred systematic care for all.
undergraduates (medicine, nursing, pharmacy), postgraduate (Diploma, Degree and 4 Med programmes), and in-service short courses. 1223 of those trained were in 8 additional countries. MPCU qualifications 5 BSc, 2 Masters, 1 PhD. 103 abstracts at national and international conferences and 11 papers published. Impact assessments include evaluation of integrated model including link nurses, outcome of PC interventions, educational impact, research capacity building, morphine use, experience of patients and staff and evaluation of specific projects.

Conclusions: Developing a strategic plan embedding a coherent and integrated approach to research allows evidence based practice to become routine and outcomes to be assessed. An integrated model allows generalist PC to be empowered with specialist support. Partnerships have allowed for wide project work and dissemination. This review is contributing to the next strategic plan.

OD 36
BALANCING USE OF OPIOIDS FOR CHRONIC CANCER PAIN: A RETROSPECTIVE ANALYSIS OF MORPHINE CONSUMPTION AND PRESCRIBING PROTOCOLS AT A TERTIARY CANCER CENTER IN INDIA

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Introduction: An unswerving accessibility to opioids is not only vital for efficient pain and palliative care but also for management of opioid dependence, a fear of addiction, restraining laws, costs, bureaucracy and difficulties with procurement and distribution limited the legitimate use of opioids for medical purposes.

Aim: To study the morphine consumption pattern and opioid-prescribing safety protocols in a tertiary cancer-care hospital in New Delhi.

Methodology: A retrospective study was performed to analyze the pattern of Morphine consumption and distribution from 2006 to 2016.

Results: Morphine Consumption showed a constant rise from 3.67 kg. in 2006 to 13.84 kg. in 2016. This steady incline was accompanied by a parallel rise in Out-patient attendance to Pain and palliative care clinic from 4245 patient visits in 2006 to 14,443 patient visits in 2016. In contrast to such a steep acclivity, the trend for Oral Morphine dispensed per patient showed only a minor increase from 0.86 grams in 2006 to 0.95 grams in 2016, with the highest being 2.06 grams of Morphine prescribed per patient visit in 2012. This was followed by a steep fall to 0.96 grams in 2014 and again to 0.95 grams in 2016. Morphine consumption trend over ten years showed similar peaks and troughs. Divergence incidence has been ‘Nil’.

Conclusion: Morphine consumption trend has, for long, been used as a yardstick to evaluate improvements in quality of pain management services.

Although the morphine consumption had increased with the number of patients, the consumption pattern did not show a comparable unvarying inclination. In cases of addiction or dependence, opioid consumption is expected to increase. However, our data show an irregular fluctuating pattern of demand and supply of morphine, suggestive of judicious use of opioids. Strict prescription protocols are followed at our center to fortify judicious use of oral Morphine for cancer pain against drug abuse. Our experience emphasizes on the imperative role of education as an effective strategy to prevent opioid abuse. A comprehensive pain assessment should also include the psychological and social components of distress.

Pain is a subjective sensation and should be treated even in case of proven addiction.

There is a need to stride away from the current milieu of ‘opioid phobia’ and ‘overprescribing’, towards a more responsible and empathetic ‘pain-free world’ by advancing patient and physician education, and more structured abuse-treatment programs.

OD 37
EXPERIENCES ON DYING AND BEREAVEMENT AMONG CAREGIVERS OF PATIENTS WITH MOTOR NEURON DISEASE

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Background: Motor Neuron Disease (MND/ALS) is a progressive fatal neurodegenerative condition. The ideal management plans in MND involve palliative care interventions from the time of diagnosis. Neuro palliative care is an emerging concept in India. At present, most of the neurodegenerative conditions are cared for at home, even when they approach death.

Aim and Objectives: The current study aims at exploring the process of end of life for MND/ALS and the carers’ experiences and sources of support at the end of life. The study also looks in to the perceived needs of the caregivers of MND patients when their loved ones approaches death.

Methods: In depth interviews were conducted with six bereaved caregivers of persons with MND who were under treatment from a national tertiary care centre for neurology at South India. Interviews were either conducted in person or through telephone. Thematic analysis was done for the interviews.

Results: Major themes derived from the interviews were: Personal distress in seeing the suffering of the loved one, Sense of relief since the suffering of loved one has ended, Family support, Need for institutional care when person with MND approaches death, Role of Palliative care agencies/ treating team in preparing and supporting caregivers for facing death of their loved ones.

Conclusion: The study throws light on the end of life care currently available and sought by the caregivers of patient’s diagnosed with MND during the terminal phase. The community and palliative care services available for the patient and family as well as the challenges faced by the family to access the services can be understood.

OD 38
THE EXPERIENCE OF ARRANGING PALLIATIVE HOME-CARE FOR PERSONNEL AND FAMILIES OF AN ARMED FORCE IN INDIA: THE CARERS’ PERSPECTIVE

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Abstracts

Introduction: Palliative care remains inaccessible to most Indians, especially in remote areas. This is the first study which tries to explore the experience of arranging palliative care at home - from the perspective of the carers in an Indian armed force.

Aim: Creating awareness to help change the attitudes, practices and policies; increasing accessibility and integration of palliative care with available healthcare services in future.

Methodology: Qualitative study based on thematic analysis of semi-structured interviews with carer’s who are either serving personnel or their dependents.

Results: Lack of accessibility to palliative care in rural areas makes arranging home care challenging for anyone in India, and so for carers in armed forces. The families stay alone and men can’t be there to look after loved ones. Constraints of leave, financial and legal problems, frequent movement and social isolation disrupt care as well as family and community support systems, leading to psycho-social problems and stress for the serving personnel as well as families.

Integration of palliative care into the existing medical services, coordinating with other agencies to provide palliative care at home along with empathetic listening, timely leave, reimbursement of expenses, increased family accommodation, guidance about benefits and considerate implementation of transfer policy can help mitigate some of their problems.

Conclusion: Carers face physical exhaustion, psycho-social, financial, legal and spiritual issues—some common to all rural Indians and others unique to armed forces. Understanding these will help providers find solutions, especially in relation to the unique needs of the men in uniform.

OD 39
Quality of Life of Ostomy Patients Attending BP Koirala Memorial Cancer Hospital, Chitwan

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Background: The global scenario shows an increase trend of ostomy surgery. And, Quality of life of ostomy patients has become a common concern. Understandings of factors that can have an impact on QoL should be assessed which will provide a guideline for improving QoL of ostomy patients.

Aims: The aim of the study is to assess quality of life of ostomy patients and to find out the association between quality of life with selected demographic variables.

Methods: A descriptive cross-sectional study was conducted to assess quality of life of ostomy patient. Ninety-four patients were selected by purposive sampling technique. COH-QOL-Ostomy questionnaire tool was used for data collection. Data was collected from Descriptive and inferential statistics were used for data analysis. The P value was estimated at 95% confidence interval with 5% permissible error.

Results: The study demonstrated that mean age of respondents was 51.10 ± 16.14 years. Permanent colostomy was common. The mean score for overall QoL was 6.50 ± 1.69. The physical domain (7.14 ± 2.32) had the highest score and spiritual (5.87 ± 1.56) had lowest. The major problems related to ostomy bag were leakage (68.90%), followed by itching around the stoma (52.70%), redness (32.40%), burning sensation (16.2%) and rashes (16.2%) respectively. Age, education, residence, occupation, duration of ostomy, reason and kind of ostomy, isolation of self from social gatherings and change in clothing style had significant effects on quality of life (p < 0.05).

Conclusion: The findings revealed that most of respondents had satisfactory QoL despite presence of ostomy. In spite of various physical problems, the respondents had relatively good score in physical domain whereas, spiritual domain had the lowest. QoL was found associated with age, educational status, residence area, change in clothing style, isolate self from social gatherings, reason for ostomy and type of ostomy at 0.05 level of significance.

OD 40
Integrating AYUSH into Oncology-Palliative Care: An Experiential Account of Half a Thousand Patients

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Introduction: Integrating complementary and alternative medicine (CAM) interventions in an oncology-palliative care setting is associated with improvement in quality of life, fatigue, psychological health and functional well-being. The Government of India is proposing to integrate AYUSH based CAM interventions in oncology and palliative care. This study is a prospective longitudinal experiential observations of a practitioner who is a palliative care physician from an Ayurveda background.

Materials and Methods: A Prospective longitudinal observational study was done on 552 patients with advanced cancer seeking palliative care consultation with a palliative care physician from an Ayurveda background and was practicing both palliative care and CAM. The study was carried out between July 2016 to August 2017. The study was conducted at various cancer hospitals where the practitioner is offering clinical services and also at private palliative care clinic. The objectives of the study were to know the following: A. What percentage of population seek CAM interventions along with palliative care? B. What did the patient’s and caregiver’s expect from CAM? C. What kind of interventions did the practitioner provide to patients seeking CAM interventions? D. What were the outcomes of these interventions?

Results: Out of 552 patients seeking palliative care consultation, two-thirds of patients [368 - 66.6%] sought CAM interventions along with palliative care. The most common reason to seek CAM consultation was to explore alternative options for disease management. However, significant proportion of patients sought CAM consultation for symptom control and improvement in quality of life. Patients seeking CAM interventions received a host of symptom specific drugs available from the Ayurveda formulary, nutritional counselling and non-pharmacological interventions. Patients receiving CAM interventions reported improvement in physical and functional well-being, improvement in fatigue and appetite and regularisation of bowel habits.

Conclusions and Future Recommendations: Integration of AYUSH based CAM interventions in oncology-palliative care patients is
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A total of 40 patients were enrolled in the study (20 in each group). Yoga is understood as mind full body. 5 hospitals in Bangalore, few Doctors, 5 elderly terminally.

Loss of appetite, also known as anorexia, is a frequent. In 2015 Nepal suffered a massive earthquake with considerable loss of life and damage to infrastructure, including healthcare facilities. No previous studies had been undertaken to assess the affect of the earthquake on the healthcare needs of people with advanced illness, frail elderly and those with serious disability.

Objective: To undertake a survey to estimate the extent of palliative care need and healthcare access in two rural districts affected by the earthquake.

METHODS: Five areas were selected with varying levels of damage and access to healthcare facilities. 100 households were surveyed in each area and those with palliative care needs identified. From these, details of diagnosis/problem suffered, performance status, symptoms, social factors, access to healthcare and effect of the earthquake were elicited.

RESULTS: 507 households surveyed with 2071 inhabitants. 85/2071 (4.2%) had palliative care needs (another 14 had expired post-earthquake). 46 (56%) had chronic illness, 31 (36%) major disability and 51 (59%) frail elderly. None had cancer and none gave a clear diagnosis. Commonest symptoms were weakness 60 (71%), breathlessness 36 (42%) and pain 26 (31%). 68 (80%) still lived in temporary shelters. 60 (70%) described quality of life as satisfactory/good. 73 (86%) accessed healthcare from the same facility after the earthquake; only 5 (6%) reporting its quality had worsened. None received comprehensive chronic disease management (CDM).

Conclusion: High levels of palliative care need were detected but access to comprehensive healthcare was lacking; little had change following the earthquake. Nonetheless, people accepted their situation with few complaints. Good systems of CDM including palliative care provision need to be developed.

OD 42
SURVEY OF THE PALLIATIVE CARE NEEDS OF PEOPLE IN RURAL NEPAL FOLLOWING THE 2015 EARTHQUAKE

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Introduction: In 2015 Nepal suffered a massive earthquake with considerable loss of life and damage to infrastructure, including healthcare facilities. No previous studies had been undertaken to assess the affect of the earthquake on the healthcare needs of people with advanced illness, frail elderly and those with serious disability.

Objective: To undertake a survey to estimate the extent of palliative care need and healthcare access in two rural districts affected by the earthquake.

METHODS: 5 hospitals in Bangalore, few Doctors, 5 elderly terminally ill patients and 5 caretakers were randomly selected and interviewed with oral questionnaire, about the necessity of Spiritual Care, the impact of yoga, meditation practice on their health, on the fear of death and on peace etc.

RESULTS: With regard to Yoga and spiritual care: 80 % Doctors say it is not their professional calling, while 60% of the patients feel it gives peace and composure, 70% caretakers felt it gives strength to withstand the situation. With regards to practice of Yoga and Meditation - Doctors says 1% physical activeness, and no change in the disease status. Patient felt 30% pain relief. Caretakers felt 50% relief due to the change of environment.

Conclusion: For Doctors and hospitals the priority is not spiritual care, it is strength to face the situation.

OD 43
MEGESTROL ACETATE VersUS Dexamethasone in Cancer Associated Anorexia Cachexia: A Randomized Controlled Pilot Trial

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Background: Loss of appetite, also known as anorexia, is a frequent and distressing symptom in patients with advanced cancer and other life-limiting illnesses. Prolonged periods of anorexia, can lead to both serious physical and psychological distress to patients and their families, which ultimately can contribute to a poorer quality of life. This study compare the clinical benefits between Dexamethasone and Megestrol acetate in an Indian setting, its positive impact on appetite, QOL, and lean body mass.

Methodology: A prospective, randomized controlled pilot study was conducted in the outpatient clinic of Department of Palliative Medicine from September to December 2015. Registered adult advanced cancer patients with Palliative Care clinic, meeting the inclusion criteria and exclusion criteria were assessed after taking informed consent, for anorexia as related to other symptom burden, measured by Edmonton Symptom Assessment Score (ESAS scale), lean body weight (by Hume's Formula) and QOL (EORTC-QOL PAL15) along with demographic details. Patients were randomized to receive tab. Dexamethasone (4 mg) or Megestrol acetate (160 mg given in divided doses) for a period of 21 days. No associated appetite stimulants or multivitamins were prescribed to study patients. All patients were encouraged to eat normal diet and provided standard medical care. Patients met the PC team or were telephonically contacted for reassessment at days 7, 21 and 35. CTRI No: REF/2015/10/009871.

Results: A total of 40 patients were enrolled in the study (20 in each group). Patients in both groups showed statistically significant improvement in appetite, lean body weight and quality of life at weeks 3 and 5, as compared to baseline. However, study failed to show any significant difference for primary (appetite improvement) and secondary (lean
Intestinal obstruction is a common complication of head and neck cancer, including oral cancer, cancer of salivary glands, oropharynx, glottis, larynx, and thyroid. Intracranial cancers were excluded. Records of patients registered in 2017 (till 28th October) were scrutinized for dysphagia and odynophagia. Associations with age, sex, radiotherapy, chemotherapy, and oral thrush were explored.

**Objectives:** To study the prevalence and pattern of dysphagia and odynophagia in head and neck cancer patients registered with Trivandrum Institute of Palliative Sciences, India.

**Methods:** Head and neck cancer includes oral cancer, cancer of salivary glands, oropharynx, glottis, larynx and thyroid. Intracranial cancers were excluded. Records of patients registered in 2017 (till 28th October) were scrutinized for dysphagia and odynophagia. Associations with age, sex, radiotherapy, chemotherapy, and oral thrush were explored.

**Results:** Of 91 patients, 71 were men (78.0%). Mean age was 60.4 years (Range 17–88). Commonest sites included tongue (24, 26.4%) followed by buccal mucosa (14, 15.4%). Table 1 shows results of univariate analysis. Multivariate analysis suggested significant risk increments of dysphagia to be 18.9 times with radiotherapy, 3.7 times with chemotherapy, and 3.9 times for men; risk increments of odynophagia were 16.1 times with oral thrush and 7.3 times with chemotherapy.

**Conclusion:** Almost half of head and neck cancer patients referred for palliative care have dysphagia or odynophagia, significantly attributable to treatment-related oesophageal toxicity. Candidiasis is the most amenable factor for screening and treatment.

**Table 1: Univariate analysis of dysphagia/odynophagia**

|                          | n   | Dysphagia, \% (%) | Odynophagia, \% (%) |
|--------------------------|-----|------------------|---------------------|
| Prevalence in all patients| 91  | 37 (40.7)        | 46 (50.5)           |
| Sex                      |     |                  |                     |
| Male                     | 71  | 31 (43.7)        | 37 (52.1)           |
| Female                   | 20  | 6 (30.0)         | 9 (45.0)            |
| Oral thrush              |     |                  |                     |
| Yes                      | 10  | 7 (70.0)         | 9 (90.0)*           |
| No                       | 81  | 30 (37.0)        | 37 (45.7)           |
| Radiotherapy             |     |                  |                     |
| Yes                      | 32  | 20 (62.8)*       | 23 (71.9)*          |
| No                       | 59  | 17 (28.8)        | 23 (39.0)           |
| Chemotherapy             |     |                  |                     |
| Yes                      | 39  | 22 (56.4)*       | 29 (74.4)*          |
| No                       | 52  | 15 (28.8)        | 17 (32.7)           |

*P<0.05
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**Introduction:** Myiasis, an infestation by fly larvae (maggots), is common problem in cancer patients with fungating wounds in the hot humid climate of India. Other factors are poverty and poor personal hygiene. Topical application of turpentine oil is commonly used for maggot removal.

**Objectives:** Management of three patients with myiasis is discussed.

**Methodology:**

**Patient 1:** 35 yrs male from lower income group with carcinoma buccal mucosa and large fungating wound on the left cheek had severe bleeding and foul smell. 1-2 Maggots observed so turpentine oil plus coconut oil in 1:1 ratio applied topically and large numbers removed daily for 4 days.

**Patient 2:** 30 yrs male of lower socioeconomic group and carcinoma tonsil with tracheostomy and ulcerative wound on right side neck complained of something coming out of tracheostomy. On examination maggots were observed. A few drops of povidone-iodine put in tracheostomy and 6-8 maggots removed. No maggots revealed on wound after topical application of turpentine oil.

**Patient 3:** 70 yrs male from middle income group, with carcinoma lower alveolus and small ulcerative wound on left cheek complained of excessive bleeding and foul smell. On examination maggots observed coming out of oral cavity. Topical application with turpentine oil and removal of maggots was done daily for 4 days. Maggots decreased in number so povidone-iodine applied and large numbers maggots removed.

**Results:** Maggot removal was successful in all three patients. Two patients were from lower income group and all three had poor personal hygiene.

**Conclusions:** Topical application of turpentine oil is effective for removal of maggots. Povidone-iodine solution may also be used.

**OD 47**

**A RANDOMISED, CONTROLLED, DOUBLE-BLIND STUDY OF ORAL METHOTRIMEPRAZINE VERSUS HALOPERIDOL IN PATIENTS WITH CANCER AND NAUSEA NOT RELATED TO THERAPY**

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**Introduction:** Haloperidol is commonly used for the treatment of nausea in palliative care patients. Methotrimeprazine (MTZ) is a broad spectrum phenothiazine. Despite the wide use of this drug in palliative care, most of the evidence supporting its use is anecdotal.

**Objective:** To compare the antiemetic efficacy of MTZ and haloperidol in a controlled trial.

**Methods:** Patients were randomized to receive blinded encapsulated MTZ (6.25 mg) or haloperidol (1.5 mg) both given orally once daily. Metoclopramide 10mg q4hourly was available as rescue. In the absence of response, the dose could be increased to twice daily (total daily dose 12.5 mg MTZ or 3 mg haloperidol). Assessments were undertaken every 24 hours. Response was defined as a ≥2 point improvement from baseline on an 11 point NRS for average nausea.

The primary endpoint was response at 72 hours. The use of rescue antiemetics, adverse effects and the complete control (CR) of nausea (response with an average nausea score of <3/10 at 72 hours) were secondary end-points.

**Results:** 121 patients were randomised to achieve the sample size of 50 participants per arm. ITT analysis revealed response rates at 72 hours of (36/57) 63.2% and (44/59) 74.6% in the MTZ and haloperidol arms respectively with CRs of 50.9% and 55.9%. Per protocol response rates in those completing 72hrs treatment were (36/49) 73.5% and (44/52) 84.6% for MTZ and haloperidol with CRs of (29/49) 59.2% and (33/52) 63.5%. Secondary analyses of response over time, and use of rescue antiemetics showed no differences between arms. Drowsiness was more common with MTZ (17.5% vs 10%, NS). Otherwise, side-effects worse than baseline were minimal.

**Conclusion:** Both MTZ and haloperidol are effective in the control of nausea in patients receiving palliative care with high response rates at 72 hours and no significant difference between arms.

**OD 48**

**GANGA PREM HOSPICE: A 6-MONTH AUDIT OF THE INPATIENT SERVICES OF THE FIRST HOSPICE IN THE STATE OF UTTARAKHAND**

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**Introduction:** Ganga Prem Hospice (GPH) has been providing free home based palliative care services to the cancer patients since 2006. Realizing the need of patients requiring inpatient palliative care services and the lack of dedicated such services in Uttarakhand; GPH opened the first inpatient hospice in 2017.

**Objectives:** The objective of this study is to present the audit of the first six months of the GPH inpatient palliative care services.

**Methods:** A retrospective review of the patient’s records admitted to the inpatient hospice from June-November 2017 to elucidate their demographic details, sources of referral, reasons for admission and outcome.

**Results:** A total of 32 cancer patients were admitted over 6-month [Table 1]. The most common primary site of cancer was head and neck (n = 13), lung (n = 3) and reproductive system (n = 3). The most common reasons for admission were management of pain, fungating wounds and respite care.

**Conclusion:** GPH through its inpatient hospice services has filled a long gap and is working tirelessly to improve quality of life of cancer patients in need of inpatient palliative care services.

**OD 49**

**HOMEOPATHIC DOMAIN ON END STAGE PATHOLOGICAL DISEASES: CANCER**

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Abstracts

**Introduction:** Cancer is the second most common cause of death in the world. It is estimated that invasive cancers are likely to develop in one of every two men and one of every three women in their life time by 2050. The study of cancer evolution and its treatment are still in its infancy with much debate about the mechanism involved and much testing of hypotheses left to be carried out.

This paper is based on a 15 yearlong study and clinical experience in the treatment and cure of diagnosed cancer cases with Homeopathic medicines. 5 cases of cured cancers are presented with substantial clinical data.

An attempt was made to explain the origin and evolution of cancer based on the natural laws of living. The genetic origin of cancer has also been explained from the view of Homeopathy. Conventional research methodologies and concepts are insufficient to explain the scientific principles involved in the Homoeopathic way of treatment. The reproducibility of results is not possible with homeopathic medicines as it is based on purely individualistic holistic mode of administration and similar conditions and platforms are not replicable. In this circumstance we are forced to assess cures from symptomatic relief and clinical investigations of individual cases as a crude and final endpoint.

**Objectives:** One of the main objectives of this 15 yearlong study is to go beyond the conventional theories of health, disease and treatment, the main focus being on the single monstrous disease Cancer. It was an attempt to prove the efficacy of Homoeopathic medicines in palliation, symptom control and cure of cancer in every stage of disease irrespective of the organ involved.

**Methods:** Five diagnosed cancer cases who had taken chemo and/or radiation therapies but failed to get total cure and recurrence were taken for the study. The patients were given Homeopathic medicines in single minimum doses and observed clinically for relief of symptoms together with laboratory and imaging investigations.

**Results:** The results have been detailed in Table 1

**Conclusion:** Homoeopathy as a healing art, based on the timeless, ageless, immutable laws of nature has surpassed all tests of time and now loom large as a complete system of medicine. It is a sad catastrophe that the wide possibilities of this unconquerable healing art are yet to be tapped to reach its full potential.

| Table 1: Diagnosis and outcomes of patients included in the study |
|---------------------------------------------------------------|
| **Diagnosis**                                               | **Past treatment taken** | **Homoeopathic medicine** | **Present status** |
| Squamous cell carcinoma lungs with metastasis               | Chemotherapy             | Apis mellifica            | Cured              |
| Adreno cortical carcinoma                                   | Surgery, chemotherapy    | Arsenicum album           | Cured              |
| Carcinoma oropharynx                                        | Surgery, chemotherapy, radiation | Calendula | Cured |
| Acute myeloblastic leukemia                                 | Chemotherapy             | Natrum sulph              | Cured              |
| Squamous small cell carcinoma with lymph node metastasis    | Chemotherapy, radiation  | Sulphur                   | Cured              |

The cured cases of cancer presented here with substantial clinical evidences are the only answers to all the questions put forward from every nook and corner. Discarding this alternative system of medicine as untruthful or bogus will deprive many an ailing human being with the possibility of the cure in the radical sense.

**OD 50**

**Inpatients Nearing End of Life: A Point Prevalence Study**

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**Objectives:** To identify the proportion of inpatients who might be identified as high risk nearing end of life in a major tertiary facility by using Gold Standards Framework (GSF), ‘The Surprize Question’ (SQ) plus 2 SPICT general criteria. Secondary outcomes were to describe clinical care and end of life care planning in identified patients and to identify the predictive accuracy of the screening tool.

**Methods:** Prospective cross-sectional study of admitted adult inpatients on one day, using 22 trained auditors.

Demographic data derived from chart review, predictive tool data based on information available and staff reports of SQ, Karnofsky Score (AKPS)and Clinical Frailty Score (CFS-9). There was no direct patient contact.

Extensive chart review of patients identified as high risk reviewed for further data following discharge. 12 month mortality data obtained from the Registry of Deaths.

**Results:** 192/540 (37%) identified as high risk, 21% 65-80 yr age, 37% > 80yrs, 8% from RACF. 9/192 had advance care plan, 45% acute resuscitation plan, 25% had been referred to Palliative Care service. 90% had an unplanned admission in previous 6 months and 36% had DEM visit.

91 patients died (18%), 72/191 from high risk group and 9/322 from low risk group with demonstration of moderate sensitivity and specificity.

**Conclusion:** The use of GSF tools are validated for first time in a major acute facility. Further multivariate modeling to identify best prognostic elements and detailed qualitative analysis of advance care planning and end of life communication during the index admissions is underway.

**OD 51**

**The Association of Financial Difficulties with End of Life Experiences of Patients with Advanced Cancer: Results from COMPASS Study**

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**Introduction:** In health care systems with large out-of-pocket expenditures such as in Singapore, advanced cancer and its treatment
may cause financial difficulties in patients. However its association with patients’ end-of-life (EOL) experiences is not fully understood.

**Objectives:** We aimed to assess the association between patients’ financial difficulties and their EOL experiences and hypothesized that patients’ financial difficulties will be adversely related to all aspects of their EOL experiences including quality of life, spiritual and psychological well-being, symptom burden, and quality of care received.

**Methods:** We used baseline survey data from a cohort study of patients with a stage IV solid cancer (n = 484) attending outpatient clinics in public hospitals in Singapore. Financial difficulties were scored by asking patients how well the amount of money they had enabled them to cover the cost of their treatment, meet daily needs and buy little ‘extras’. Quality of life was measured through FACT-G, spiritual well-being by FACIT-Spiritual, psychological well-being through Hospital Anxiety and Depression scale. Quality of communication with doctors, nursing care and health care coordination was assessed. We used separate multivariate linear/logistic regressions to test our hypotheses, adjusting for patient demographics and perceived cancer severity.

**Results:** Patients with greater financial difficulties experienced poorer physical, social, emotional, functional and spiritual well-being, nursing care quality and health care coordination; had greater symptom burden; and were more likely to experience anxiety and depressive symptoms (p < 0.05 for all).

**Conclusion:** Greater equity in financing of health care would reduce patients’ financial difficulties and likely improve their EOL experience.

**OD 52**

**Prognostic Awareness and Expected Survival among Advanced Cancer Patients in Singapore: Results from COMPASS Cohort Study**

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**Introduction:** Awareness about prognosis can help cancer patients make informed treatment decisions. However, previous studies indicate that many cancer patients are unaware of their prognosis and often overestimate their expected survival.

**Objectives:** We examined patients’ prognostic awareness (i.e. beliefs about being cured and expected survival length) and its predictors: (i) stage of initial diagnosis, (ii) extent patients feel informed about their cancer (iii) age.

**Methods:** Baseline data from the Cost and Medical Care of Patients with Advanced Serious Illnesses in Singapore (COMPASS) cohort study comprising 484 patients with stage IV solid cancer was used. Multivariate logistic regressions were used for analysis.

**Results:** Despite data suggesting otherwise, 31% of patients stated that their current treatments would cure them. Among patients who were aware that they had advanced cancer (72%), patients whose initial diagnosis was advanced stage cancer had higher odds of reporting that they would be cured than patients diagnosed at an earlier stage (OR = 1.86; p < 0.05). 55% of the sample expected to survive for more than 5 years. Patients who considered themselves ‘very informed’ about their cancer had higher odds of reporting a longer expected survival than others (OR = 1.81; p < 0.05). Patients who were older had a lower odds of reporting a shorter expected survival than younger ones (OR = 0.97; p < 0.05).

**Conclusions:** These results indicate many advanced cancer patients are unrealistically optimistic about their prognosis. However, it may be that patients are not truly uninformed but rather report what they hope, as opposed to what they believe. This could explain why patients whose initial diagnosis was early stage cancer—and are thus more likely to have experienced treatment failure and dashed hope—are likely to be more realistic about their prognosis.

**OD 53**

**Supportive and Palliative Care Indicator Tool for Low Income Settings (SPICT-LIS™): A Resource for Identifying Patients Who Would Benefit from Palliative Care**

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**Introduction:** Palliative care is a core element of Universal Health Coverage (UHC), a vital aspect of Sustainable Development Goal 3 – ‘ensuring health and wellbeing for all’. To realize UHC, generalists must develop palliative care skills and incorporate these into their practice. SPICT™, a simple A4-sized tool, was designed to enable clinicians to identify patients with any condition needing palliative care. Led by developers in Scotland, SPICT has undergone several iterations and translation into 6 other languages. Whilst SPICT has been used in low-income settings (LIS) it requires contextual modifications to optimize its content for use in these areas.

**Objectives:** To develop SPICT-LIS for low-income settings to enable generalists working in these locations to identify patients needing palliative care.

**Methods:** Health and social care professionals working in low-income settings in several countries in South Asia and Sub-Saharan Africa have been undertaking a Delphi project to develop SPICT-LIS. Using wide-ranging palliative care experience, engaging local clinical networks and by reviewing the literature surrounding SPICT, they are working collaboratively to agree appropriate modifications to the tool.

**Results:** Examples of modifications made include: not using ‘continuous oxygen therapy’ as an indicator as it is unlikely to be available and adding new sections on end-stage infections, including HIV and multidrug resistant tuberculosis and surgical conditions (e.g. burns) that are more likely to require palliative care in LIS.

**Conclusions:** SPICT-LIS™ is in the final stages of development, will be launched in early February 2018 and will be available for distribution and discussion at the conference.
OD 54
END OF LIFE CARE: DECISION MATTERS

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Introduction: End of Life Care: normally we understand it in Hospital among the Machines, away from home. It becomes disastrous from the perspective of patient, who is suffering from diseases, pain and lack of Confidence and Spiritual support.

Objectives: To take decision for patient to spent peaceful life in terminal stage.

Methods: One of my known was suffering from Lymphoma and nobody in family was aware as they were taking treatment for anemia in local area and then private hospital. When they were referred to Lucknow SGPGIMS, family called me for help. After seeing the report I got to know it’s suspicion of Lymphoma. Nobody was aware and were waiting for the report of Biopsy. I told them in general manner and discussed with Doctor. Before Biopsy report due to critical condition patient was admitted in Emergency. After checking report I convince the family for not taking treatment and take the patient back to home as even Doctor was not sure how much time is left but still provided their best efforts. Next day I got call from the family that Doctor is asking for Central Line but the condition was too critical so I discussed and denied for the same.

Results: Patient was in lap of her husband and small kid, away from hospital but near to home with some of relatives when the last breath was taken in midway in peaceful environment.

Conclusions: Decision was tough but we have to think about the person who can spent last moments with peace and happiness.