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## EAPC Abstracts

### EAPC President's Welcome

Dear Colleagues, Dear friends,

On behalf of the EAPC Board of Directors, and as President, I am delighted to welcome you to our 11th EAPC World Research Congress Online, the first ever palliative care virtual Congress. Although not exactly as we had originally planned, this congress has been a long time in the planning, and it has been my honour to work with a dedicated group of colleagues, who have worked tirelessly to bring this programme to fruition. Without your valuable contributions through the submission of regular and late breaking abstracts, this would not have been possible.

As you will all know the congress was originally planned to take place in Palermo in May 2020. This was a great choice of venue for our Research Congress for many reasons. Palermo hosted the 7th EAPC World Congress in 2001 at the same venue. Reflecting on the programme from 2001, the hot topics of the day included: Controversies in ethics, Prognostication at the end of life, Ethics within Latin Europe, Controversies in therapeutics, End-of-life care decision-making and End-of-life care in children. All giving the impression that many of the issues remain the same. Unfortunately, a global pandemic prevented the congress going ahead in person as planned. For us all, in particular for the Local Organisers led and inspired by the Local Chair Sebastiano Mercadante this was and remains a great disappointment. We would all have enjoyed the great weather, the wonderful city, the good food and the warm Sicilian hospitality! My special thanks go to Sebastiano and his team, their role in the conference organisation was enormous! Mille grazie per tutto President's quello che avete fatto. Speriamo nel futuro! We look forward to hearing Sebastiano's piano recital during the online opening ceremony.

There are many other people to thank for helping to bring this online event to fruition. Our Scientific Committee and the two chairs Marie Fallon and Lieve van den Block, our debt of thanks for their hard work over many long hours. We would also like to thank our Conference Partner, BIBA GROUP and Alessia Milella for supporting us through difficult times. Of course, my personal thanks to EAPC Head Office, Julie, Cathy, Avril and Claudia for the logistics, organisation and managing all the other EAPC demands at the same time as bringing a world research congress online together. I would also like to give sincere thanks to Augusto Caraceni and Alice Gallivanone, European Association for Palliative Care Research Network who have worked tirelessly to bring the programme together and ensure that the congress goes ahead despite the circumstances.

So, I wish us all a wonderful Congress Online, combined with the hope that we will soon meet again personally

Professor Christoph Ostgathe  
President, European Association for Palliative Care

## **Welcome from the Chairs of the Scientific Committee**

Out of challenges, good can emerge and we believe that this virtual EAPC Research Congress is a great example of this.

We have been impressed by the determination of all involved in palliative care to continue to share research, build on the current challenges and move onwards and upwards.

You will experience a wide spectrum of topics and presentations and we have of course the unforeseen inclusion of COVID 19 within both the late breaking abstracts and plenary sessions.

This unique Congress will be a foundation stone for the future, ensuring that we can maintain high quality research in palliative care, through sharing, discussion, iteration and ongoing communication.

A huge thank you to all of you for the effort you have made on so many levels to attend the Congress

Professor Marie Fallon

Professor Lieve Van den Block

Co-Chairs, Scientific Committee

11<sup>th</sup> EAPC World Research Congress Online

## Welcome from the Chair of the EAPC Research Network

As the chair of the EAPC Research Network, I would like to share with you a few thoughts about the 11th World Research Conference online of the EAPC. I will share with you a few thoughts about a few subjects: sadness, compassion and closeness, pride, values and our responsibilities.

We are sad of course. We are sad because the reason why the EAPC research conference is going online in 2020 is a tragedy affecting all of us. COVID-19 infected millions of people. Hundreds of thousands died and tens of thousands died in Italy and in Lombardy region where I work and from where I am writing this introduction. Spain, UK, Brazil, USA . . . so many other countries are facing the same emergency and we do not yet know how this will affect our lives and our way to be together and meet in the future. Palermo is missing this conference. Italy is missing this conference, Sebastiano Mercadante, our host in Palermo, is missing this conference.

So, we need to exercise compassion and closeness. Compassion towards ourselves, our patients, their families and our colleagues who on the front line have been fighting - are still fighting - to save lives and to give relief in the meager course of acute respiratory failure. To support families who cannot join together, who cannot even meet or hold the hand of somebody who is imminently dying alone.

We have to be proud as a palliative care community because the palliative care community is affected by this situation. We are seeing the effects. I have shared the experiences of many palliative care professionals: physicians, nurses, psychologists. We have to see and to reflect on what this experience has to teach to us as palliative care professionals. What can we contribute with our palliative care competence and research? For this reason, three special sessions about the impact of the pandemic on palliative care have been included in this congress.

What about our values and our responsibilities? I think that the second reason why our research conference is so important in these extraordinary circumstances is that palliative care needs, the needs of patients and families affected by incurable illnesses are still there and are waiting for our appropriate responses.

How can we guarantee that, in front of the pandemic emergency, palliative care is still available to those who need it? In the previous months we have been fighting, we have been afraid to be infected, we have been afraid to infect our patients. And for this reason, I invite you even more to emphasise the needs as a palliative care community to reflect on our values, on our research and clinical commitment. I am sure we can do it; I am sure we can all do it together in this online research conference.

I am sure that also this online conference will achieve our goals as palliative care clinicians and researchers, not to add another paper to our CV, not to increase our impact factor but to improve our patients care and quality of life.

In 11<sup>th</sup> EAPC World Research Congress, while we will miss the beautiful blue sky and the warm welcoming of Palermo, we still have the opportunity to reflect on what is essential in palliative care and share our thoughts. In the meantime, I take this opportunity to thank all who helped in making this conference possible again: Professor Marie Fallon and the Scientific committee, Professor Christoph Ostgathe and the Board of the EAPC, Julie Ling, EAPC CEO, and the EAPC Head Office, Alessia Milella and Biba Group and the EAPC Research Network assistant Alice Gallivanone.

In the end I would like to thank you all for participating; be proud of your work and of our values.

Professor Augusto Caraceni  
Chair, EAPC Research Network

**Results:** 28 questionnaires were duly completed and analyzed. The mean age of the respondents was 42.8 years, mostly female (96.4%). Majority of them considered the live funeral had positive influences on different aspects:

1. For patient: It could help to perform life review (94.7%), to face oneself honestly (78.8%), to reduce regrets (78.8%), and so on.
2. For family: It could help to comfort and support each other (84.2%), to alleviate the anticipatory grief (73.7%), and so on.
3. For clinical care: It could help to improve patient-provider relationship (78.9%) and medical decision making (78.9%).

In addition, most of the palliative care team members (75.0%) thought it would be worth assisting a patient in holding such a living funeral if necessary.

**Conclusions:** The live funeral may be beneficial to the patient, to the family, and to the clinical care. Because there is almost no associated medical evidence, we hope this study may provide a reference to decide if a medical team should assist a patient's live funeral.

**Abstract number: P02-200**

**Abstract type: Poster**

**Spiritual distress in women with breast cancer: a cross-sectional study**

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**Background/aims:** Breast cancer is the leading cause of cancer in women and the second most common cancer overall (Bray et al., 2018). Cancer affects all dimensions of patients' life and is a condition for spiritual distress, that is expressed by cancer patients as suffering and related to lack of meaning in life.

The aim of this study is to assess spiritual distress in women with breast cancer.

**Methods:** Cross-sectional and prospective study, using a random sample of women with breast cancer undergoing chemotherapy. Participants from a south hospital in Portugal were invited to participate in this study and fulfilled a questionnaire comprising the "Spiritual Distress Scale" (SDS). This scale is composed of 30 items and scores range between 30 and 120. Data collection was performed from February to June, 2019. Statistical analysis was performed using SPSS 23. Ethical approval was obtained from the institution.

**Results:** Participants were 102 women; mean age of 60.29 (sd=± 11.37); 62% were married; with a religious affiliation (96.8%); and with stage III (45.1%) and stage II of breast cancer (33.3%). The mean score of SDS was 56.61 (sd=± 14.24). In this study 39% women with breast cancer experienced moderate spiritual distress and 4% experienced high levels of spiritual distress. Cronbach's Alpha was 0.90.

**Conclusions:** Women with breast cancer experience spiritual distress at some level. The scores of the SDS are calling for an urgent inclusion of spiritual care, that could include the assessment, diagnosis, intervention and assessing the outcomes. Also, this scale is a reliable instrument to be used in nursing care aiming to assess spiritual distress and to drive nursing intervention. The inclusion of spirituality could be, then, facilitated by nurses using this scale and including in nursing records.

**References:** Bray, F. et al. (2018). Global Cancer Statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA: A Cancer Journal for Clinicians*, 68(6):394-424.

**Abstract number: P02-201**

**Abstract type: Poster**

**Religious commitment in cancer patients: a cross-sectional study**

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**Background/aims:** Patients who go through the experience of having cancer usually face a difficult and stressful time. Religion and spirituality are coping strategies that these patients often use to overcome this life event. The aim of this study is to assess religious commitment among cancer patients.

**Methods:** Cross-sectional and prospective study, conducted in a hospital in the south of Portugal. Data collection was conducted between February and June, 2019. Patients with 18 years old and over with all types of cancer were considered eligible to participate. A random sampling technique was implemented to recruit the participants. Data collection instrument was a questionnaire that took 10 minutes to fill, and included the Portuguese version of Belief into Action Scale (BIAC) to assess religious commitment. BIAC is composed of nine items and the scores ranged between 9 and 90. The data was analyzed using SPSS 23. The study was approved by the Ethics Committee of the institution where the study was conducted.

**Results:** A total of 278 participants were included (females  $n=164$ , 59 %; males  $n=113$  41%); age mean was 60.47 years old ( $\pm$ SD 11.59); amplitude ranged between 27 to 83; 94.4 % had a religious affiliation and the majority were Christian. The BIAC mean total score was 26.63 ( $\pm$ SD 12.56). However, females (Mean= 29.33, SD=  $\pm$ 12.47) scored higher religious commitment than males (Mean= 22.76, SD= $\pm$ 11.76). Cronbach Alpha was 0.85, which showed a good internal reliability. The item with the lowest score was item 3 (Mean=1.51) and the highest item 4 (Mean=6.27).

**Conclusions:** Although the scores of religious commitment were not high, the religious and spiritual dimension of cancer patients is a crucial dimension in dealing with this life-threatening disease, especially in female patients. Healthcare providers should increase awareness of patients' religious and spiritual practice and belief in order to promote and enhance holistic care.

**Abstract number: P02-202**

**Abstract type: Poster**

**The challenges and opportunities for corneal and tissue donation from patients with progressive life-limiting conditions - a systematic review and narrative synthesis**

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**Background/aims:** Tissue transplantation can potentially improve the quality of life for thousands of people donors. Donation of solid organs following brain stem death is common however patients with progressive life-limiting conditions (LLC) are also eligible to donate tissue e.g. corneas. Given there is a world-wide shortage of tissues available for donation palliative care and long term care settings are important sites to consider transplantation, however this is not common practice.

**Aim:** To synthesise the evidence of challenges and opportunities for patients with LLCs to donate tissue and corneas.

**Methods:** Relevant databases were systematically searched for papers published between Sept 2005 and March 2019 using the terms: LLC, palliative, tissue/corneal donation. A narrative review synthesis process advocated by Popay was used to develop a thematic analysis. Papers containing data about barriers and/or facilitators for tissue donation from people with LLC were included. Studies were appraised for quality and data synthesised narratively.

**Results:** 3 service improvement audits, 2 qualitative and 4 quantitative studies of mixed quality were included. 4 main themes were identified from studies of health professionals (HP), patients and families: awareness about tissue donation, role of healthcare professionals to initiate discussions, decision making & consent to donate and facilitators for donation discussion with patients with progressive LLCs. Barriers encompassed lack of knowledge about donation and uncertainty