Introduction Liaison psychiatry is based on a practice that lies on the interface between psychological, sociological and biological factors of illness. Cancer is a devastating disease. For many patients the occurrence of it is synonymous of chronic, severe or lethal outcome. It is important for health professionals to be aware of the psychological suffering of these patients and promote a proper use of specialized consultations in order to increase and improve adherence to treatment.
Aims To make known the reality of referral to a Psycho-Oncology Liaison consult and its context in literature.
Methods Data collection on applications for the 1st request to Psycho-Oncology liaison consults occurred between 2010–2012 in the variables, gender, age, reason for referral, psychiatric history, cancer diagnosis, knowledge of the referral and who does (patient/family/service) and psychiatric diagnosis. Statistical analysis with Microsoft Excel 2010®.
Results It was found that there were 83 applications during the three years, 24 men and 59 women. The most prevalent cancer diagnoses were breast cancer (29.89%) and colorectal carcinoma (19.28%). Most patients had knowledge of the request (75.9%). The reason was mostly for Anxiety and Depression (33.73%).
Conclusion Cancer disease coupled with feelings of loss of autonomy, hopelessness and pain can lead the patient to develop psychopathology of anxious-depressive disorders. This condition may hamper the normal recovery of the patient. The promotion of mental well-being in cancer patients is critical to recovery and leads to a better adherence to treatment, inclusive can influence survival.
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EV856

The sedation could consist in a therapeutic strategy in advanced cancer conditions

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Introduction The sedation could consist in a therapeutic strategy in advanced cancer conditions.
Objective To study the drugs administered to patients under Palliative Care Sedation (PCS) audits effects on vital signs.
Methods Our retrospective study included 101 oncological patients with mean age of 66.5 ± 13.4 years old and mean weight of 48.5 ± 3.36 kg, under PCS. The data were analysed applying the test of Wilcoxon.
Results The drugs administered to these patients under PCS were morphine 55 mg/kg/day associated to midazolam 52.5 mg/kg/day (Morph/Midazo) or the association of morphine 55 mg/kg/day, midazolam 52.5 mg/kg/day and neuroleptics such as chlorpromazine 54.5 mg/kg/day or haloperidol 13.25 mg/kg/day (Morph/Midazo/Neurol). The values of vital signs of these patients when the sedation was initiated were: systolic blood pressure 116.55 ± 16.98 mmHg, diastolic bloodpressure73.17 ± 10.55 mmHg, heart rate 83.41 ± 16.25bpm, respiratory rate 19.39 ± 3.97 rpm and body temperature $35.91 \pm 0.57\,^{\circ}$C. No significant differences between these groups were observed. Vital signs measures were collected 48 hours before the patient's death. Significant reduction in systolic blood pressure 77.5 mmHg, diastolic blood pressure 43.3 mmHg were observed in the group (Morph/Benzo/Neurol). The Wilcoxon test for independent samples to a significance level of 5% we obtain a *P*-value of 0.01. The sedation period was 2.56 ± 0.23 days.
Conclusion Neuroleptic, a central nervous system (CNS) depressant drug, when associated to other two depressants (morphine/midazolam), conducted to the patient's vital signs reduction. Considering the short period of time between the beginning of sedation and the patients' death; and that palliative sedation should not include the hastening of patients' death, we suggest a better drug association criteria.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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Pain and treatment options

EV858

Pain management in context of emotionally unstable personality disorder

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Introduction Emotionally unstable personality disorder (EUPD) is characterised by Pain Paradox. The response for acute, self-induced pain seems to be attenuated while chronic, endogenous pain is usually intolerable. Pain management of this group of patients poses many difficulties, including discrepancies between subjective and objective pain assessment, patients' demands for strong analgesics and impact on relationship with other professionals.
Objectives and aims The purpose of the study was to review pain management options for persons diagnosed with EUPD and complaining of chronic pain.
Methods MEDLINE and PsycINFO databases were searched for all English-language articles containing the keywords "chronic pain", "pain management", "borderline personality disorder", and "emotionally unstable personality disorder".
Results Seventeen relevant papers were identified. Suggested first step in pain management was ongoing clarification with EUPD patients that analgesics are unlikely to fully treat their pain and support of non-pharmacological approaches to pain, including cognitive-behavioural strategies. Regarding pharmacology, liberal use of non-addicting analgesics was recommended with highly conservative use of opioid analgesics. Importance of evaluation and treatment of any underlying mood and/or anxiety syndromes was stressed as well as liaison with other professionals (e.g. psychologists, neurologists, orthopaedics, and physiotherapists).
Conclusions Patients with EUPD often report chronic pain, which can only be managed by close collaboration of professionals from different disciplines.
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EV859

Duloxetine added to tramadol in chronic pain syndrome

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Introduction About 15–20% of the population suffering from the chronic pain. Over time, chronic pain can result in different emotional problems, social isolation, sleep disturbances, which reduce the quality of life. Chronic pain syndrome (CPS) indicates persistent pain, subjective symptoms in excess of objective findings, associated dysfunctional pain behavious and self-limitation in activities of daily living. Duloxetine is a potent antidepressant approved by the Food and Drug Administration for the chronic musculoskeletal disorder, diabetic neuropathic pain, fibromyalgia, generallized anxiety disorder and major depressive disorder.
Objective To determine the effect of duloxetine on the reduction of pain and psychosocial suffering.
Aims The goal of the treatment should be to effectively reduce pain while improving function and reducing psychosocial suffering.
Methods Thirty-six adult, nondepressed patients, already on tramadol therapy were included. Patients with VAS (visual analogue scale) ≥ 4were treated with duloxetine for 13 weeks. We measured pain intensity with the McGill Pain Questionnaire-Short Form (MPQ-SF) and compared VAS before starting the treatment with duloxetine and weekly for 13 weeks.
Results Pain response was defined as a 30%decrease in the MPQ-SF. A total of 62.5% of the sample met these criteria for response. Among them, 13.8% of patients were discontinued because of adverse effects. Duloxetine significantly improved functioning and the quality of life in patients with CPS.
Conclusions Because of it is analgesic properties, duloxetine in the lower antidepressant doses (60 mg taken ones daily) combined with tramadol (another analgesic agent) can be useful in CPS for patients who do not respond satisfactory to monotherapy.
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EV860

Prevalence of different pain categories based on pain spreading in older adults in Sweden: A multilevel association with socio-demographic characteristics, comorbidities and drug consumption (Pain S65+)

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Introduction Understanding of factors related to chronic pain in elderly is limited.
Objectives and aims To estimate the prevalence of pain categories based on spreading of pain on the body and to investigate how such spreading is related to demographic variables, pain intensity, comorbidities and medication in an elderly general population in southeastern Sweden.
Methods A total of 6611 adults aged ≥ 65 years participated (mean age = 76.2; SD = 7.4). Pain categories were assessed by a self-reported postal questionnaire covering 45 anatomical predefined pain regions along with demographics, pain intensity during previous seven days, comorbidities and medication. Poisson regression models with robust error variance were used for data analyzing.
Results The prevalence of pain spreading categories was: chronic local pain (CLP) 16%; chronic regional pain medium (CRP-Medium) 17%; chronic regional pain heavy (CRP-Heavy) 5% and chronic widespread pain (CWSP) 2%. Overall, increased prevalence for CRP-Heavy and CWSP in subjects 75–79 years old compared to those 65–69, 70–74, 80–84 and ≥ 85 years were revealed. In men, 75–79 years old, CRP-Heavy was more common than in the other pain categories. In women, 75–79 years old CWSP, was more common than in the other pain categories. Pain intensity was strongly associated with all pain categories ($P < 0.001$). CLP was associated with trauma, rheumatoid arthritis, cancer, prescribed and non-prescribed analgesics. CRP-Medium was associated with rheumatoid arthritis, CRP-Heavy with rheumatoid arthritis and lung diseases and CWSP with rheumatoid arthritis and prescribed analgesics ($P < 0.001$).
Conclusions Our findings elucidate heterogeneity of pain in elderly which has to be further investigated.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV861

Distinct subgroups derived by cluster analysis based on pain characteristics and anxiety-depression symptoms in Swedish older adults with chronic pain (PainS65+)

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Introduction There is a lack of research on subtypes of chronic pain (CP) characteristics in the elderly.
Objective To scrutinize major subgroups based on pain aspects and psychological factors on an elderly population.
Aims To determine possible differences between the derived subgroups with respect to pain aspects and anxiety-depression symptoms, health aspects and health care costs.
Methods A cross-sectional study was implemented. A large sample of 2300 individuals (M = 75.9 years, SD = 7.4) participated. Self-reported postal measurements regarding pain intensity, spreading of pain, anxiety and depression (General well-being schedule [GWBS]), and pain catastrophizing [PCS]) were used as classification variables. A two-step cluster analysis was employed. We further investigated whether the derived subgroups experienced different quality of life and general health. Calculations regarding health care costs were also performed.
Results Two major subgroups were identified: one low symptom severity subgroup (Cluster 1; $n = 1326$; 58%) and one high symptom severity subgroup (Cluster 2; $n = 974$; 42%). There were statistical significant differences on pain intensity, spreading of pain, anxiety, depression and pain catastrophizing between the two subgroups ($P < 0.001$). Significant lower levels for quality of life and general health ($P < 0.001$) were found for the high symptom severity subgroup. Health care costs in the high symptom severity subgroup were significantly higher than those of the low symptom severity subgroup ($P < 0.001$).
Conclusions Our findings exhibit the necessity for subgroup-specific treatment services for improving pain management and reducing health care costs in the elderly.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EV862

Ziconotide and amnesia: A case report

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