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.
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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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Duloxetine added to tramadol in chronic pain syndrome

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